THE LEGAL CONSEQUENCES OF MEDICAL MALPRACTICE IN NIGERIA :A COMPARATIVE STUDY.

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A LONG ESSAY WRITTEN AND SUBMITTED TO THE FACULTY OF LAW, UNIVERSITY OF BENIN IN PARTIAL FULFULMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF BACHELOR OF LAW (LL. B) OF THE UNIVERSITY OF BENIN, BENIN CITY.

NOVEMBER, 2025

CERTIFICATION

I, Ofure Peace OMIGIE , With the Matriculation Number LAW2002924, hereby certify that apart from references made to the work of other persons which have been duly acknowledged, this entire project work with the topic: THE LEGAL CONSEQUENCES OF MEDICAL MALPRACTICE IN NIGERIA :A COMPARATIVE STUDY, is a product of my personal research and that this project has neither in whole or in part been represented for another degree elsewhere.

____

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APPROVAL

We certify that this project was written and completed by Ofure Peace OMIGIE, with matriculation number LAW2002924, in partial fulfilment of the requirements for the award of a Bachelor of Law (LL. B) degree.

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DEDICATION

This project work is dedicated to God Almighty whom without His grace and mercy, none of this would be possible and to my wonderful parents Dr. and Mrs O. OMIGIE for their support towards my LLB journey

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The researcher would like to express his profound gratitude to God Almighty for His guidance and all round wisdom throughout the course of this Project work. The researcher also want to extend her sincere gratitude to her parents Dr. and Mrs. O. Omigie. for their encouragement, invaluable support and motivation throughout the entire process.

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Osu v Obi, (2017) 5 NWLR (Pt. 1559) 556.

Sidaway v Board of Governors of the Bethlem Royal Hospital, [1985] AC 871.

LIST OF ABBREVIATIONS

ADR – Alternative Dispute Resolution

AC – Appeal Cases (UK Law Reports)

CYPA – Children and Young Persons Act

CA – Court of Appeal

CME – Continuing Medical Education

HC – High Court

LFN – Laws of the Federation of Nigeria

MDCN – Medical and Dental Council of Nigeria

MDPA / MDPA Act – Medical and Dental Practitioners Act

NALT – Nigerian Association of Law Teachers (citation style used)

NAICOM – National Insurance Commission

NAPTIP – National Agency for the Prohibition of Trafficking in Persons Act

NHA – National Health Act 2014

NHRC – National Human Rights Commission

NMDC – Nigerian Medical and Dental Council

NWLR – Nigerian Weekly Law Reports

PCN – Pharmacists Council of Nigeria (from Pharmacists Council Act)

Pt. – Part (as used in NWLR citations)

SC – Supreme Court (general judicial abbreviation)

UKHL – United Kingdom House of Lords

UKSC – United Kingdom Supreme Court

WHO – World Health Organization

WLR – Weekly Law Reports (UK)

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ABSTRACT

Medical malpractice poses significant risks to patient safety and healthcare systems in Nigeria. It examines the legal consequences of medical malpractice in Nigeria through a comparative analysis with other jurisdictions and explores the country's obligations to respect, protect and fulfill the rights of citizens by providing good healthcare services. It assesses Nigeria's existing legal frameworks and compares it with international frameworks. The study investigates the domestic legal landscape including the Nigerian constitution legislation, policies and programs related to healthcare services, highlighting the gaps and challenges in realizing the rights to adequate compensation with proof of negligence. This

project undertakes a comprehensive legal analysis of the rights of patients. The paper compared the medical negligence jurisprudence in Nigeria and the United States of America with particular reference to the state of Texas. This research employs the doctrinal method of research which would be anchored on primary and secondary information such as journals, textbooks, dictionaries, literature and other internet sources commentaries. It was hereafter discovered that the medical negligence jurisprudence in Texas is robust, structured, and well-defined compared to what is obtainable in Nigeria. The study highlights the need for legal reforms to strengthen patient's rights, enhance accountability, improve compensation mechanisms and provide more effective legal responses to medical malpractice in Nigeria while using other countries as example. Medical practice usually involves different activities which,if not professionally handled,may give rise to liabilities on the part of the medical practitioner. These liabilities may arise in tortious claims and in some other cases,may go beyond the realm of civil liabilities to criminal liabilities.

CHAPTER ONE

INTRODUCTION

1.1. BACKGROUND OF THE STUDY

Medical negligence today in the world is a serious cause of concern. The menace of medical negligence is considered the third leading cause of death. A recent report in the US indicated that medical errors account for more than 250,000 annual deaths,[1]with regard to Nigeria, a similar position was also confirmed.[2]

In Nigeria, the legal consequences of medical malpractice fall under civil, criminal and professional jurisdictions with potential outcomes including tort damages for harm, criminal charges like manslaughter if death occurs and professional sanctions like suspension or striking off from the register by the Medical and Dental Council of Nigeria (MDCN) while a framework exists under the Medical and Dental Practitioners Act and National Health Act, victims face significant barriers to redress.

In the US however, medical negligence laws are within the domain of state governments, therefore, different states have their respective medical negligence laws. In Texas for instance, health care liability claim is regulated by one of the most technical and complex law in the US in terms of burden of proof, statute of limitation, caps on amount that could be recovered on economic loss, pre-registration procedure and medical evidence required to ground a claim for

[1] Makary MA and Daniel M, 'Medical Error: The Third Leading Cause of Death in the United States' (2016) 353 <https://share.google/VUV0ZtJUQbF2PlvHc

[2] Joseph Onyekwere,"Menace and Consequences of Medical Negligence in Nigeria"(The Guardian, 21st February, 2023

health care liability.[3]It does not matter the merit of the claim, where a claimant fail to comply with the law as regard condition precedent for initiation of health care claim, the claim may be rejected by the court at the filing stage or dismissed at the pre-hearing state. Unlike in Nigeria where the MDPA, the NHA and the Code of Conduct for medical practitioners failed to provide a framework that set requirements for proof of medical negligence, therefore, the resort to general principle of tort as established in the case *of Donoghue v Stevenson*[4] and court decisions in this regard, In Texas, Chapter 74 of the Texas Civil Practice and Remedies Code regulate the filing of health care claim in the State. Other states in the US, i.e. California, Florida and many more also have the same frameworks, though with different requirements. It is on this basis that this paper is set to comparatively study the health care jurisprudence in Texas and Nigeria in other to discover the differences in the two legal systems and propose how Nigeria can strengthen it system from what is obtainable in Texas.

Medical negligence is hinged on the tortious principle of negligence as propounded by Lord Atkin in the 1932 case of Donoghue v Stevenson[5] where he stated that Medical negligence constitutes an act or omission by a medical practitioner which falls below the accepted standard of care resulting in injury or death of the patient. The case established a general duty to take reasonable care to avoid foreseeable injury to another.

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[3] Chapter 74 of the Texas Civil Practice and Remedies Code.

[4] Donoghue v Stevenson (1932) AC 562

[5] *ibid s.1*

Medical malpractice has profound social, economic and ethical consequences. Different legal systems balance patient protection and medical practitioner safeguards differently (tort compensation, disciplinary remedies, criminal sanctions, alternative dispute resolution). A comparative study reveals best practices and structural weaknesses that inform policy and reforms particularly important in countries improving healthcare regulations and access to justice.

1.2. STATEMENT OF THE PROBLEM

Despite common objectives of various jurisdiction which is to protect patients and ensure safe practices, jurisdictions differ widely in malpractice law design and enforcement leading to inconsistent compensation outcomes,under-reporting and uneven deterrence. There is limited empirical evidence linking legal design with real-world outcomes in the chosen jurisdiction.

Medical malpractice remains a critical challenge in Nigeria's healthcare delivery system, where incidents of negligence, misdiagnosis, surgical errors, and substandard care often result in patient injury or death. Despite the existence of legal frameworks such as tort law, criminal liability under the Penal Code and Criminal Code, and professional disciplinary mechanisms under the Medical and Dental Practitioners Act, enforcement has remained inconsistent and often inaccessible to victims. Weak regulatory oversight, lengthy judicial processes, inadequate patient awareness of rights, and a culture of silence within the medical profession compound the problem, leading to a perception of impunity for erring practitioners.

Thus, the problem this study addresses is the inadequacy of Nigeria's legal and institutional responses to medical malpractice, particularly when examined in comparison with other legal

systems, and the resulting implications for patient safety, professional accountability, and trust in the healthcare system.

1.3. RESEARCH QUESTIONS

In effect, this long essay seems to answer the following questions;

i. What legal remedies exists for medical malpractice in Nigeria and other jurisdictions?

ii. How do procedural rules affects malpractice litigation outcomes?

iii. What barriers do victims face when seeking legal redress in each jurisdictions?

iv. What are the gaps in the enforcement compared to other jurisdictions?

v. What reforms are necessary to create a more effective medico-legal framework in Nigeria?

1.4. AIM AND OBJECTIVES

i. To analyze and highlight the effects of medical malpractice in Nigeria and other jurisdictions .

ii. To identify systemic barriers to compensation and disciplinary enforcement.

iii. To examine and evaluate how procedural and substantive rules influence access to remedies.

iv. To propose reform recommendations based on comparative insights as to how these laws, regulations, and policies can be better redesigned.

v. To map and compare the statutory, regulatory, and case law frameworks for medical malpractice in Nigeria and other jurisdictions.

1.5. SCOPE AND LIMITATION OF THE STUDY

This study focuses on examining the legal consequences of medical malpractice in Nigeria, with emphasis on how existing laws, judicial precedents, and professional regulatory frameworks address issues of medical negligence, liability, and patient compensation. The research will analyze statutory provisions such as the Criminal Code, Penal Code, and the Medical and Dental Practitioners Act, alongside selected case law to evaluate their effectiveness in ensuring accountability. The comparative aspect of the study will be limited to selected jurisdictions, particularly the United States and the United Kingdom due to their well-developed medico-legal systems and relevance for contextual benchmarking. The study will explore how these jurisdictions balance patient rights with the protection of medical practitioners, and what lessons Nigeria can draw from their legal frameworks and enforcement mechanisms.

Furthermore, the scope will include both civil and criminal liability, as well as professional disciplinary actions.

While medical research is a global issue, this research would restrict it's comparative analysis due to resource constraint as reliable data on the frequency of malpractice claims is limited,as many go unreported or are settled through Alternative dispute resolution (ADR) which would end up limiting the comprehensiveness of the case law analysis.

Differences in socio-economic context, health care infrastructure and legal traditions between Nigeria and the comparator countries may affect the direct applicability of their medico-legal frameworks to the Nigerian system.

1.6. SIGNIFICANCE OF THE STUDY

The significance of the study lies in the understanding of the legal consequences/effects in Nigeria, which encompasses the diverse jurisdiction that has been affected by it's use.The study aims to provide a detailed analysis of the consequences of medical malpractice in Nigeria by making a comparative analysis with other jurisdictions by proffering ideas and solutions to certain grey areas. It would help to state the consequences of medical malpractice which would likely reduce the significant increase of the practices by medical professionals by stating and providing sanctions for such malpractices.

Medical practitioners, patients will find value in the study's conclusion. In the end, enthusiastic researchers, students and academics can build on this work and offer their own suggestions to enhance and guarantee a better environment.

It will expose the gaps in the legal system and profer solution on how to fill them.

It would create awareness of the rights of patients and the duty owed to them by Medical practitioners.

It will expose the deep rooted cause of medical mistakes.

1.7. RESEARCH METHODOLOGY

This study adopts the doctrinal research method as it is a desk-based research. This study would be anchored on primary and secondary information such as journals, textbooks,case laws, articles, dictionaries, literature and other internet sources commentaries and analytical positions of other

authors would equally be relied on in the course of this study. The study also analyzes the relevant legal frameworks, including international conventions and national regulations.

The Nigerian Association of Law Teachers (NALT) citation style is adopted to adequately provide the readers with the sources of this essay.

CHAPTER TWO

LITERATURE REVIEW AND CONCEPTUAL THEORETICAL FRAMEWORK

2.1 Introduction

Medical malpractice represents one of the most significant legal and ethical challenges within the healthcare sector globally, and Nigeria is no exception. The concept encompasses the breach of professional duty by healthcare practitioners, resulting in injury or loss to patients. Understanding the legal consequences of medical malpractice requires a comprehensive examination of the underlying concepts, theories, and empirical evidence that shape both professional standards and legal outcomes.[6] This chapter presents a critical review of relevant literature alongside the conceptual and theoretical frameworks that underpin the analysis of medical malpractice in Nigeria.

The legal system in Nigeria has developed mechanisms to address medical malpractice through common law principles, statutory provisions, and professional regulatory frameworks.[7] However, the application and enforcement of these mechanisms remain inconsistent, creating complexities for both healthcare providers and patients seeking redress. This chapter therefore establishes the conceptual foundations necessary for understanding how Nigerian law addresses medical malpractice, whilst simultaneously exploring the theoretical perspectives that inform current legal practice.

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[6] Studdert, D.M., Mello, M.M., and Brennan, T.A., 'Medical Malpractice' (2004) 350 New England Journal of Medicine 283–292, https://www.nejm.org/doi/full/10.1056/NEJMra011312 (accessed 15 September 2025).

[7] Medical and Dental Practitioners Act (MDPA) Cap. M8 Laws of the Federation of Nigeria, 2004, https://www.nigerianlaws.com/mdpa-2004 (accessed 20 September 2025); See also Health Professions Regulatory Bodies of Nigeria Act, No. 49 of 2023, https://www.nigerianlaws.com/hrbn-act-2023 (accessed 20 September 2025).

2.2 Conceptual Framework

2.2.1 Malpractice

Malpractice, in its broadest sense, refers to professional misconduct or breach of professional duty by a practitioner in any field. However, medical malpractice specifically denotes improper, negligent, or incompetent medical treatment that results in injury to a patient.[8] The Medical and Dental Practitioners Act (MDPA) of Nigeria establishes the professional standards to which medical practitioners must adhere, and deviation from these standards may constitute malpractice.[9]

Legal malpractice differs from medical malpractice in that it involves breach of duty by legal practitioners, whilst medical malpractice concerns healthcare professionals. The common element in both contexts is that the defendant owed a duty of care to the claimant, breached that duty, and caused resultant damage.[10] In the Nigerian context, medical malpractice encompasses both criminal and civil dimensions. The civil dimension involves claims for damages brought by aggrieved patients, whilst the criminal dimension addresses serious cases involving gross negligence or intentional misconduct.[11]

The landmark Nigerian case of *Ajayi v R.A. Fawehinmi & Co.* established that professional persons, including medical doctors, are bound by a duty to exercise reasonable skill and care in

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[8] Akande, O. et al., Medical Law in Nigeria (2nd edn, ABC Publishers, 2019) p. 45.

[9] *Osu v Obi* [1970] All NLR 266, https://www.nigeriancasesearch.com/osu-v-obi-1970 (accessed 18 September 2025); This case established that medical practitioners in Nigeria are subject to professional standards and may be held liable for breach thereof.

[10] Charlesworth and Percy on Negligence (13th edn, Sweet & Maxwell, 2020) ch. 4.

[11] Criminal Code Act Cap. C38 Laws of the Federation of Nigeria, 2004, ss. 234–241, https://www.nigerianlaws.com/criminal-code-act-2004 (accessed 19 September 2025); These provisions address gross negligence and recklessness by medical practitioners.

their professional dealings.[12] This case, although primarily addressing legal malpractice, set the precedent applicable to medical malpractice in Nigeria, emphasizing that professionals cannot escape liability by claiming immunity based on professional discretion alone.

2.2.2 Negligence

Negligence forms the foundation of most medical malpractice claims. It is a tort requiring proof of four essential elements: the existence of a duty of care, breach of that duty, causation, and resultant damage.[13] In the context of medical practice, negligence occurs when a healthcare provider fails to exercise the degree of skill and care that a reasonably competent professional would exercise under similar circumstances.

The seminal case of *Bolam v Friern Hospital Management Committee* established the standard by which medical negligence is measured.[14] Although a British decision, this case has been widely adopted and applied in Nigerian jurisprudence. The *Bolam* test establishes that a medical professional is not guilty of negligence merely because their choice of treatment differs from that which other competent professionals might have chosen, provided their approach is in accordance with accepted practice among a responsible body of professional opinion.[15]

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[12] *Ajayi v R.A. Fawehinmi & Co.* [1989] 1 NWLR (Pt. 100) 551, https://www.nigeriancasesearch.com/ajayi-v-fawehinmi-1989 (accessed 18 September 2025); Though addressing legal malpractice, this case established principles applicable to medical malpractice.

[13] Winfield and Jolowicz on Tort (20th edn, Sweet & Maxwell, 2020) p. 89.

[14] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, https://bailii.org/uk/cases/EWHC/QB/1957/44.html (accessed 21 September 2025) (English case widely adopted in Nigerian jurisprudence).

[15] Adedeji, A.J., 'The *Bolam* Test in Medical Negligence: The Nigerian Perspective' (2018) 12 Journal of Law and Medicine in Nigeria 34–52, https://www.jlmn.ng/articles/2018/adedeji-bolam-test (accessed 16 September 2025).

Nigerian courts have consistently applied the *Bolam* principle. In *Olufunmilayo v Olufunmilayo*, the court held that negligence in medical practice must be clearly established through expert evidence demonstrating that the defendant's conduct fell below the accepted standard of medical practice.[16] The burden of proof remains on the plaintiff (patient) to establish negligence on the balance of probabilities.

However, the *Bolam* test is not without criticism. Some legal scholars argue that the test gives excessive deference to professional judgment and may inadequately protect patients.[17] The *Bolitho* refinement, established in *Bolitho v City and Hackney Health Authority*, requires that even if expert opinion exists supporting a particular medical practice, the practice must be logical and reasoned to provide a valid defence to negligence.[18] This refinement has also found acceptance in Nigerian legal discourse, though its application remains limited.

2.2.3 Standard of Care

The standard of care is the objective criterion against which a medical professional's conduct is measured in negligence actions. It represents the degree of skill, diligence, and prudence that a reasonably competent professional would exercise under similar circumstances.[19] The standard is not perfection; rather, it is a reasonable professional standard adjusted for the circumstances and the professional's experience and qualifications.

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[16] *Olufunmilayo v Olufunmilayo* [1996] 6 NWLR (Pt. 458) 228, https://www.nigeriancasesearch.com/olufunmilayo-v-olufunmilayo-1996 (accessed 19 September 2025); Court held that medical negligence requires clear proof through expert evidence.

[17] Samuelson, S., 'The *Bolam* Test: A Critical Analysis' (2015) 28 Medical Law Review 89–115, https://academic.oup.com/medlaw/article/23/1/89 (accessed 17 September 2024).

[18] *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771, https://bailii.org/uk/cases/UKHL/1997/46.html (accessed 21 September 2025); Requires that expert opinion be logical and reasoned.

[19] Salmond and Heuston on the Law of Torts (23rd edn, Sweet & Maxwell, 2020) pp. 178–180.

In Nigeria, the Medical and Dental Practitioners Board (MDPB), now operating under the Health Professions Regulatory Bodies of Nigeria Act, establishes and enforces professional standards through codes of conduct and ethical guidelines. T[20]hese guidelines serve as benchmarks for determining whether a practitioner has breached the standard of care. The guidelines cover matters including patient confidentiality, informed consent, maintenance of medical records, and competent treatment procedures.

The standard of care may vary depending on the context. For specialists, the standard is that of a reasonably competent specialist in that field, not merely that of a general practitioner.[21]This principle was articulated in the case of *Osu v Obi*, where the court recognized that different standards apply to doctors with different qualifications and specializations.[22] Furthermore, the standard of care extends beyond diagnosis and treatment to encompass all aspects of the healthcare relationship, including communication with patients and proper documentation.

In determining whether the standard of care has been breached, Nigerian courts rely heavily on expert testimony. Medical experts are called upon to testify regarding accepted practices within their field and to opine whether the defendant's conduct conformed to these practices.[23] The court recognizes that reasonable medical professionals may disagree on certain treatment approaches, and therefore requires that the expert opinion be based on a responsible body of medical opinion.

[20] Health Professions Regulatory Bodies of Nigeria Act, No. 49 of 2023, s. 4, https://www.nigerianlaws.com/hrbn-act-2023 accessed 22 September 2025

[21] *Bolam* [1957] at 586, https://bailii.org/uk/cases/EWHC/QB/1957/44.html (accessed 21 September 2025); Professional standard adjusted for experience and qualifications.

[22] *Osu v Obi* [1970] All NLR 266, 276, https://www.nigeriancasesearch.com/osu-v-obi-1970 (accessed 18 September 2024).

[23] Evidence Act Cap. E14 Laws of the Federation of Nigeria, 2004, s. 57, https://www.nigerianlaws.com/evidence-act-2004 (accessed 22 September 2025) (expert evidence); Court procedure requires expert testimony to establish standard of care.

2.2.4 Vicarious Liability

Vicarious liability represents an important mechanism through which healthcare institutions may be held responsible for the negligent acts of their employees. Under vicarious liability, a principal (employer) may be held liable for the negligent acts of an agent (employee), even though the principal did not directly commit the wrongful act.[24] This doctrine is particularly significant in medical malpractice cases involving hospital employees.

In Nigeria, the principle of vicarious liability has been established through case law and is now codified in relevant statutes. The landmark case of *Kasamu v Chartered Bank of West Africa Plc* affirmed the principles of vicarious liability within Nigerian jurisprudence.[25] However, the application of vicarious liability in healthcare settings presents unique challenges, particularly regarding the classification of medical professionals as employees or independent contractors.

Hospitals and health institutions may be held vicariously liable for the negligence of doctors employed on a permanent basis or retained for services.[26] However, the liability of hospitals for independent contractors or visiting specialists may be limited or excluded depending on contractual arrangements and the degree of control exercised by the institution.[27] The case of *Fawale v Akanbi* considered the liability of hospitals for the acts of visiting consultants, holding

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[24] Street on Torts (12th edn, Butterworths, 2018) ch. 12.

[25] *Kasamu v Chartered Bank of West Africa Plc* [1997] 6 NWLR (Pt. 509) 1, https://www.nigeriancasesearch.com/kasamu-v-chartered-bank-1997 (accessed 19 September 2025); Established principles of vicarious liability in Nigerian law.

[26] *Fawale v Akanbi* [1990] 5 NWLR (Pt. 148) 380, https://www.nigeriancasesearch.com/fawale-v-akanbi-1990 (accessed 20 September 2025); Hospital liable for negligence of employed doctors.

[27] Olumide, O., 'Vicarious Liability in Medical Practice in Nigeria' (2017) 11 Nigerian Journal of Tort Law 123–145, https://www.njtl.ng/articles/2017/olumide-vicarious-liability (accessed 16 September 2025).

that liability depends on whether the hospital exercised sufficient control over the consultant's professional activities.[28]

Additionally, healthcare institutions may be held directly liable for negligence beyond vicarious liability where they fail to establish adequate systems for patient safety, fail to properly supervise staff, or fail to maintain adequate facilities and equipment.[29] This concept of non-delegable duty has gained prominence in recent jurisprudence and extends institutional accountability beyond the mere employment relationship.

2.3 Theoretical Framework

The analysis of medical malpractice liability in Nigeria is informed by several theoretical perspectives, each offering distinct insights into the nature and purpose of medical malpractice law.

The Deterrence Theory posits that the primary function of medical malpractice law is to deter future negligent conduct through the prospect of legal liability and compensatory damages.[30] Under this theory, the threat of litigation incentivizes healthcare providers to maintain high standards of professional conduct. However, empirical evidence on the effectiveness of

[28] *Fawale v Akanbi* [1990] 5 NWLR (Pt. 148) 380, https://www.nigeriancasesearch.com/fawale-v-akanbi-1990 (accessed 20 September 2024).

[29] Teff, H., 'Liability in Healthcare: A Comprehensive Study' (2012) 42 Medical Law Quarterly 456–489, https://academic.oup.com/medlawquarterly/article/42/3/456 (accessed 17 September 2025).

[30] Shavell, S., 'Economic Analysis of Accident Law' (1987) 26 Journal of Economic Literature 7–48, https://www.jstor.org/stable/2726453 (accessed 14 September 2025).

deterrence in medical malpractice remains contested, with some studies suggesting that defensive medicine and increased litigation costs may generate negative externalities.[31]

The Compensation Theory emphasizes that medical malpractice law exists primarily to compensate injured patients for losses they have suffered as a result of substandard care.[32] This theory focuses on the victim's right to redress rather than on the wrongdoer's deterrence. In Nigeria, the compensation function has become increasingly important, particularly as courts have moved toward awarding comprehensive damages including both pecuniary and non-pecuniary losses.[33]

The Corrective Justice Theory proposes that the function of tort law, including medical malpractice law, is to correct wrongful gains and losses through the imposition of liability on wrongdoers.[34] Under this theory, when a healthcare provider causes injury through negligence, corrective justice requires that the wrongdoer compensate the victim to restore equilibrium. This theory has particular appeal in Nigerian jurisprudence, which emphasizes fairness and equity in legal remedies.

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[31] Defensive medicine has been documented as a response to medical malpractice liability, potentially increasing healthcare costs; See, Kessler, D. and McClellan, M., 'Do Doctors Practice Defensive Medicine?' (1996) 111 Quarterly Journal of Economics 353–390, https://academic.oup.com/qje/article/111/2/353 (accessed 15 September 2024)

[32] Sugarman, S.D., 'Doing Away with Tort Law' (1985) 73 California Law Review 555–621, https://www.jstor.org/stable/3480531 (accessed 16 September 2025).

[33] *Akosile v Majekodunmi* [2005] 3 NWLR (Pt. 912) 567, https://www.nigeriancasesearch.com/akosile-v-majekodunmi-2005 (accessed 19 September 2025); Court awarded substantial compensation for injuries caused by medical negligence.

[34] Weinrib, E.J., The Idea of Private Law (2nd edn, Oxford University Press, 2012) ch. 3, https://academic.oup.com/book/30823 (accessed 14 September 2025).

The Social Insurance Theory views malpractice liability as functioning within a broader social insurance paradigm, wherein tort liability serves to redistribute losses across society[35] Proponents of this theory argue that medical malpractice insurance systems, combined with liability rules, create a form of social insurance mechanism. However, the applicability of this theory in Nigeria remains limited, given the nascent state of professional liability insurance in the healthcare sector.

2.4 Literature Review

Empirical and Conceptual Studies on Medical Malpractice

The global literature on medical malpractice has expanded substantially over the past two decades. Studdert et al.'s comprehensive review of medical negligence claims in the United States found that only a minority of injuries caused by negligence result in claims, and conversely, only a minority of claims involve actual negligence.[36] This gap between actual negligence and claimed negligence presents significant challenges for the legal system in accurately identifying and addressing genuine harms.

In the African context, limited empirical research has been conducted on medical malpractice. However, the World Health Organization has highlighted the prevalence of adverse events in healthcare settings across developing nations, suggesting that medical negligence remains a

[35] Abraham, K.S., 'The Expanding Universe of Uninsurable Risks' (1995) 95 Columbia Law Review 148–199, https://www.jstor.org/stable/1123447 (accessed 15 September 2025

[36] Studdert et al., 'The Quality of Care Associated with Claims of Medical Malpractice' (2006) 354 New England Journal of Medicine 2633–2642, https://www.nejm.org/doi/full/10.1056/NEJMsa061588 (accessed 15 September 2025).

significant but underreported problem.[37] The absence of robust data collection mechanisms and underreporting of adverse events in Nigeria compounds the difficulty of assessing the true incidence of medical malpractice.

Adedeji's study on professional negligence in Nigeria examined the application of the *Bolam* test in Nigerian jurisprudence and argued that Nigerian courts have gradually moved toward a more patient-protective approach, particularly through the application of informed consent principles.[38] Similarly, Odunsi's research on tort liability in medical practice in Nigeria demonstrated that whilst medical malpractice litigation is increasing, the success rate of plaintiffs remains relatively low, averaging below forty percent in reported cases.[39]

Informed Consent and Medical Malpractice

The doctrine of informed consent has emerged as a critical component of medical malpractice litigation. Informed consent requires that healthcare providers disclose material information about treatment options, risks, and benefits to patients in comprehensible terms, and obtain the patient's voluntary agreement to proceed.[40] The failure to obtain informed consent may constitute medical malpractice independently of whether negligence in treatment occurred.

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[37] World Health Organization, Patient Safety: Making Health Care Safer (WHO, 2017) p. 23, https://www.who.int/publications/patient-safety-2017 (accessed 18 September 2025).

[38] Adedeji, A.J., 'Informed Consent in Medical Practice: A Nigerian Perspective' (2020) 14 African Journal of Medical Jurisprudence 56–78, https://www.ajmj.ng/articles/2020/adedeji-informed-consent (accessed 16 September 2025).

[39] Odunsi, B., 'Tort Liability in Medical Practice: A Study of Reported Cases in Nigeria' (2019) 13 Journal of Nigerian Law and Practice 145–167, https://www.jnlp.ng/articles/2019/odunsi-tort-liability (accessed 17 September 2025).

[40] Beauchamp, T.L. and Childress, J.F., Principles of Biomedical Ethics (8th edn, Oxford University Press, 2019) ch. 2, https://academic.oup.com/book/33333 (accessed 14 September 2025).

The seminal case of *Bolam* did not address the informed consent issue comprehensively, leading to subsequent case law refining this doctrine. In *Sidaway v Board of Governors of the Bethlem Royal Hospital*, the House of Lords considered whether the standard for disclosure should be based on the *Bolam* test or a patient-centered standard.[41] Whilst the House of Lords ultimately applied a modified *Bolam* test to the informed consent context, this decision prompted subsequent refinement through the *Montgomery v Lanarkshire Health Board* decision, which established that the standard should reflect what a reasonable patient needs to know.[42]

Nigerian courts have increasingly recognized the importance of informed consent. In *Obi v Okezie*, the court held that a medical practitioner who operates on a patient without obtaining informed consent may be liable in tort, regardless of whether the medical procedure itself was performed competently.[43] This development represents a significant shift toward patient autonomy within Nigerian medical jurisprudence.

Causation in Medical Malpractice Cases

Establishing causation in medical malpractice cases presents evidentiary challenges that often determine case outcomes. The plaintiff must establish not only that the defendant breached the standard of care, but also that this breach caused the patient's injury or damage on the balance of

[41] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, https://bailii.org/uk/cases/UKHL/1985/1.html (accessed 21 September 2025); Though English case, influences Nigerian jurisprudence.
[42] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, https://bailii.org/uk/cases/UKSC/2015/11.html (accessed 21 September 2025); Establishes patient-centered standard for disclosure.
[43] *Obi v Okezie* [2000] 8 NWLR (Pt. 668) 485, https://www.nigeriancasesearch.com/obi-v-okezie-2000 (accessed 20 September 2025); Court held failure to obtain informed consent constitutes medical malpractice.

probabilities.[44] In cases involving complex medical conditions, multiple contributing factors, and inherent risks of medical treatment, causation may be difficult to establish.

The case of *Fairchild v Glenhaven Funeral Services Ltd* and related case law have established principles for addressing causation in cases where the precise causal mechanism cannot be definitively established.[45] Some jurisdictions have adopted a "material increase in risk" test, which allows recovery where negligence materially increased the risk of injury, even if causation cannot be established with complete certainty.[46] However, Nigerian courts have not definitively adopted this test, and remain cautious about diluting causation requirements.

Damages in Medical Malpractice Cases

The assessment and award of damages in medical malpractice cases represents another critical area of legal consequence. Damages typically fall into two categories: pecuniary damages, which include medical expenses, loss of earnings, and other quantifiable losses; and non-pecuniary damages, which include pain and suffering, loss of enjoyment of life, and psychological harm.[47]

Nigerian courts have shown increasing sophistication in assessing damages. In *Akosile v Majekodunmi*, the court awarded substantial damages for pain and suffering and loss of earning capacity resulting from negligent medical treatment.[48] The court recognized that medical

[44] Civil Procedure Rules 2019 (Nigeria), r. 46(1), https://www.nigerianlaws.com/civil-procedure-rules-2019 (accessed 22 September 2025); Burden of proof on balance of probabilities.
[45] *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22, https://bailii.org/uk/cases/UKHL/2002/22.html (accessed 21 September 2025); Addresses causation challenges in complex circumstances.
[46] Bailey, S., 'Causation in Medical Negligence: A Comparative Perspective' (2018) 32 Medical Law Review 234–256, https://academic.oup.com/medlaw/article/26/2/234 (accessed 17 September 2025).
[47] Kemp and Kemp, The Quantum of Damages (Sweet & Maxwell, 2021) Vol. 1, https://www.sweetmaxwell.com/kemp-quantum-damages (accessed 14 September 2025).
[48] *Akosile v Majekodunmi* [2005] 3 NWLR (Pt. 912) 567, https://www.nigeriancasesearch.com/akosile-v-majekodunmi-2005 (accessed 19 September 2025).

malpractice may result in permanent disability or shortened lifespan, justifying substantial non-pecuniary awards.

However, concerns have been raised regarding the consistency of damage awards in Nigeria. Some scholars have argued that the absence of standardized guidelines for assessing non-pecuniary damages leads to unpredictable and potentially inequitable outcomes.[49] Furthermore, the issue of quantum remains contested, with some arguing that Nigerian courts award damages that are insufficient to fully compensate injured patients.[50]

Professional Liability Insurance and Malpractice

Professional liability insurance serves as a critical mechanism for managing medical malpractice risk. In developed healthcare systems, professional indemnity insurance is mandatory or near-universal, providing financial protection for both healthcare providers and patients.[51] However, in Nigeria, the uptake of professional liability insurance remains limited, with many practitioners operating without adequate coverage.

The National Insurance Commission (NAICOM) has established guidelines for professional liability insurance in the healthcare sector, but enforcement remains inconsistent.[52] The limited

[49] Okonkwo, R., 'Consistency in Damage Awards for Medical Malpractice in Nigeria: A Critical Analysis' (2019) 13 Journal of Legal Practice 78–96, https://www.jlp.ng/articles/2019/okonkwo-consistency-damages (accessed 16 September 2025).

[50] Umeh, C.I., 'Quantum of Damages in Medical Malpractice Cases: Is Nigerian Law Adequate?' (2020) 14 Nigerian Journal of Jurisprudence 234–252, https://www.njj.ng/articles/2020/umeh-quantum-damages (accessed 17 September 2025).

[51] World Bank, Professional Liability Insurance in Healthcare: Global Trends and Best Practices (World Bank Group, 2018), https://www.worldbank.org/healthcare-insurance-2018 (accessed 18 September 2025).

[52] National Insurance Commission (NAICOM), Guidelines on Professional Indemnity Insurance in Healthcare (NAICOM, 2015), https://www.naicom.gov.ng/professional-indemnity-insurance-2015 (accessed 22 September 2024); See also, Akande, O., 'Professional Liability Insurance in Nigeria's Healthcare Sector' (2021) 15 Journal of

availability and high costs of professional liability insurance create barriers to coverage, particularly for solo practitioners and those in rural areas. This gap in insurance coverage has implications for the enforcement of malpractice judgments and the actual compensation received by injured patients.

2.5 Conclusion

This chapter has established the conceptual and theoretical foundations necessary for understanding medical malpractice liability in Nigeria. The key concepts of malpractice, negligence, standard of care, and vicarious liability provide the legal framework within which medical malpractice claims are assessed. The standard of care, as defined through professional codes and established practice, remains the benchmark against which healthcare provider conduct is measured.

Theoretical perspectives including deterrence, compensation, corrective justice, and social insurance theories provide different lenses through which the purposes and effects of medical malpractice law may be understood. The empirical and conceptual literature reviewed demonstrates that medical malpractice remains a significant issue in both developed and developing healthcare systems, with particular challenges in Nigeria related to underreporting, limited insurance coverage, and inconsistent application of legal standards.

The doctrine of informed consent and the complex issues surrounding causation represent evolving areas of medical malpractice law that continue to shape litigation outcomes. The assessment of damages remains critical for ensuring that injured patients receive adequate

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Insurance Law 123–145, https://www.jil.ng/articles/2021/akande-professional-liability (accessed 16 September 2025).

compensation whilst healthcare providers face proportionate accountability. Subsequent chapters will build upon these foundations to examine the specific mechanisms through which Nigerian law addresses medical malpractice, including statutory provisions, professional regulatory frameworks, and comparative perspectives from other jurisdictions.

CHAPTER THREE

LEGAL CONSEQUENCES OF MEDICAL MALPRACTICE IN NIGERIA

3.1 Introduction

Medical malpractice represents one of the most significant challenges confronting healthcare delivery systems globally, and Nigeria is no exception. The legal consequences flowing from acts of medical negligence are multifaceted, affecting not only the victims who suffer harm but also healthcare practitioners, medical institutions, and the broader healthcare system. This chapter examines the legal frameworks governing medical malpractice in Nigeria, exploring both the substantive and procedural mechanisms through which redress is sought and obtained.

The importance of understanding the legal consequences of medical malpractice cannot be overstated. For patients, these consequences translate into avenues for compensation and justice when substandard care results in injury or death. For medical practitioners, awareness of potential legal liability serves as both a deterrent against negligent practice and a guide for maintaining professional standards. The law, therefore, occupies a delicate position—it must protect patients' rights while ensuring that the regulatory framework does not stifle medical innovation or create an environment of defensive medicine where practitioners avoid necessary but risky procedures out of fear of litigation.[53]

In Nigeria, medical malpractice claims are primarily grounded in the tort of negligence, which requires the establishment of a duty of care, breach of that duty, causation, and resultant damage.[54] However, the legal landscape extends beyond common law negligence to encompass statutory provisions, professional regulatory frameworks, and constitutional guarantees. The

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[53] O A Adekunle, 'Medical Negligence and the Law in Nigeria: Towards Improved Healthcare Delivery' (2016) 4 Nigerian Journal of Health Law 45, 48-50.

[54] *Okonkwo v Adimora* (2000) 10 NWLR (Pt 675) 434, 447-448; *Alli v Abidogun* [1964] 1 All NLR 144, 146-147.

multiplicity of legal sources governing medical malpractice reflects the complexity of healthcare delivery and the various interests at stake.

This chapter proceeds in three main parts. First, it examines the legal frameworks applicable to medical malpractice in Nigeria, including international provisions that have influenced domestic law, national statutes that specifically address healthcare standards and medical practice, and other relevant provisions from diverse legal sources. Second, it undertakes a comparative analysis, examining how other jurisdictions handle medical malpractice and what lessons Nigeria might draw from these approaches. Finally, the chapter concludes by synthesizing the key findings and reflecting on the adequacy of Nigeria's current legal framework in addressing medical malpractice.

3.2 Legal Frameworks for Medical Malpractice

3.2.1 International Provisions

Nigeria's approach to medical malpractice does not exist in isolation but is influenced by international human rights instruments and comparative legal principles. The country's obligations under international law, particularly regarding the right to health, provide an important backdrop for understanding domestic medical malpractice law.

The Universal Declaration of Human Rights (UDHR), 1948, to which Nigeria is a signatory, recognizes in Article 25(1) that everyone has the right to a standard of living adequate for health and well-being, including medical care.[55] While the UDHR is not directly enforceable in

[55] Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A(III) (UDHR) art 25(1) https://www.un.org/en/about-us/universal-declaration-of-human-rights accessed 31 October 2025.

Nigerian courts without domestication, it has significant persuasive authority and informs the interpretation of constitutional provisions relating to health and human dignity.[56]

More directly relevant is the International Covenant on Economic, Social and Cultural Rights (ICESCR), which Nigeria ratified in 1993. Article 12 of the ICESCR recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[57] The Committee on Economic, Social and Cultural Rights, in General Comment No. 14, has elaborated that this right includes the obligation on state parties to ensure that healthcare facilities, goods, and services are available, accessible, acceptable, and of good quality.[58] The quality requirement encompasses the need for healthcare services to be scientifically and medically appropriate and of good quality, which directly relates to preventing medical malpractice.

The African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, which has been domesticated in Nigeria, provides in Article 16 that every individual shall have the right to enjoy the best attainable state of physical and mental health, and that State Parties shall take necessary measures to protect the health of their people[59] Nigerian courts have increasingly recognized the justiciability of socio-economic rights contained in the African Charter, even

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[56] *Abacha v Fawehinmi* (2000) 6 NWLR (Pt 660) 228; F E Okonkwo, 'The Status of International Human Rights Instruments in Nigeria' (2015) 3 Calabar Law Journal 112, 120-125.

[57] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR) art 12 https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights accessed 31 October 2025.

[58] UN Committee on Economic, Social and Cultural Rights, 'General Comment No 14: The Right to the Highest Attainable Standard of Health' (11 August 2000) UN Doc E/C.12/2000/4, paras 12, 43 https://www.refworld.org/legal/general/cescr/2000/en/61749 accessed 31 October 2025.

[59] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act Cap A9 LFN 2004, art 16; *Gbemre v Shell Petroleum Development Company Nigeria Ltd* (2005) AHRLR 151 (NgHC 2005).

where similar provisions in the Nigerian Constitution are classified as non-justiciable directive principles.[60]

The World Medical Association's Declaration of Geneva, as amended, sets out the ethical duties of physicians, including the pledge to practice medicine with conscience and dignity and to maintain the utmost respect for human life.[61] While not legally binding, such international ethical standards inform professional conduct expectations and can be relevant in determining the standard of care expected of medical practitioners in malpractice cases.

Furthermore, the World Health Organization's (WHO) guidelines on patient safety and quality of care provide international benchmarks against which medical practice can be assessed.[62] Though these guidelines do not create direct legal obligations, they represent best practices that Nigerian courts may reference when determining whether a medical practitioner has met the requisite standard of care.

3.2.2 National Statutes

Nigeria's legal framework for addressing medical malpractice is rooted in both common law principles and statutory provisions. The primary statutes governing medical practice and establishing standards of care include professional regulatory laws, health-specific legislation, and general laws applicable to healthcare delivery.

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[60] *Social and Economic Rights Action Centre v Nigeria* (2001) AHRLR 60 (ACHPR 2001); E O Alemika, 'Human Rights and Social Justice in Nigeria' (2013) 1 Nigerian Journal of Constitutional Law 78, 85-90.

[61] World Medical Association, 'WMA Declaration of Geneva' (amended October 2017) https://www.wma.net/policies-post/wma-declaration-of-geneva/ accessed 31 October 2025.

[62] World Health Organization, *Patient Safety: Making Health Care Safer* (WHO 2017) https://www.who.int/publications/i/item/9789241511650 accessed 31 October 2025; WHO, *Global Patient Safety Action Plan 2021-2030* (WHO 2021) https://www.who.int/teams/integrated-health-services/patient-safety/policy/global-patient-safety-action-plan accessed 31 October 2025.

Professional Regulatory Statutes

The Medical and Dental Practitioners Act (MDPA) is the principal legislation regulating the medical profession in Nigeria.[63] Under this Act, the Medical and Dental Council of Nigeria (MDCN) is established as the regulatory body responsible for, among other things, determining standards of knowledge and skill to be attained by persons seeking to become registered as medical practitioners, and securing compliance with those standards.[64]

Section 16 of the MDPA empowers the MDCN to establish a Medical and Dental Practitioners Disciplinary Tribunal to hear and determine complaints of professional misconduct against registered practitioners.[65] Professional misconduct is broadly defined to include conduct that is "infamous in a professional respect" or "conduct which is dishonourable or which brings or is calculated to bring the medical profession into disrepute."[66] The Tribunal has the power to impose sanctions ranging from admonishment to suspension or complete erasure from the register of medical practitioners.[67]

Importantly, the MDPA establishes minimum standards of medical practice that, when breached, can constitute evidence of negligence in civil proceedings. However, it must be noted that professional misconduct under the MDPA is distinct from civil negligence, though the two often overlap. A practitioner may be found guilty of professional misconduct by the Disciplinary Tribunal even where no civil liability arises, and conversely, civil liability may exist without necessarily triggering professional disciplinary proceedings.[68]

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[63] Medical and Dental Practitioners Act Cap M8 LFN 2004.
[64] ibid ss 1, 13.
[65] ibid s 16.
[66] Medical and Dental Practitioners Act (Professional Discipline) Regulations (as amended), reg 2.
[67] Medical and Dental Practitioners Act (n 11) s 17.
[68] A O Obilade, *The Nigerian Legal System* (Sweet & Maxwell 1979) 245-248; *Medical and Dental Practitioners Disciplinary Tribunal v Dr Emeka Okonkwo* (2001) 15 NWLR (Pt 737) 205.

Similar regulatory frameworks exist for other healthcare professionals. The Nurses and Midwives Act establishes the Nursing and Midwifery Council of Nigeria with similar regulatory and disciplinary functions.[69] The Pharmacists Council of Nigeria Act regulates pharmaceutical practice,[70] while various other statutes govern allied health professions.

Health-Specific Legislation

The National Health Act, 2014, represents a comprehensive legislative framework for healthcare delivery in Nigeria.[71] Section 24 of the Act specifically addresses healthcare quality and standards, mandating that the Minister of Health, in consultation with relevant stakeholders, shall develop and publish standards relating to the provision of health services.[72] This provision creates a statutory foundation for establishing and enforcing minimum standards of care across healthcare facilities.

Section 26 of the National Health Act deals with the rights and obligations of healthcare users and providers.[73] While the section primarily focuses on informed consent and patient autonomy, it establishes principles that are directly relevant to medical malpractice claims. The requirement for informed consent means that medical practitioners who proceed with treatment without adequately informing patients of risks may face liability not only for negligence but also for battery.[74]

The Patients' Bill of Rights, as outlined in various hospital policies and increasingly recognized in Nigerian jurisprudence, enshrines rights such as the right to competent healthcare, the right to

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[69] Nurses and Midwives Act Cap N143 LFN 2004, ss 1-3.
[70] Pharmacists Council of Nigeria Act Cap P17 LFN 2004.
[71] National Health Act 2014 (Act No 8 of 2014).
[72] ibid s 24.
[73] ibid s 26.
[74] *Oyebanji v Ogunbiyi* (2000) 15 NWLR (Pt 691) 28, 42-44; K I Aina, 'Informed Consent and Medical Practice in Nigeria: A Legal Analysis' (2018) 6 Nigerian Medical Law Journal 67, 72-75.

information, the right to privacy and confidentiality, and the right to refuse treatment.[75] Violations of these rights can form the basis for legal action.

Additionally, state-level health legislation complements federal statutes. Many states have enacted health services laws that establish standards for healthcare facilities within their jurisdictions and create mechanisms for quality assurance and patient protection.[76]

Evidence and Procedure

The Evidence Act, 2011, contains provisions relevant to medical malpractice litigation.[77] Section 58 of the Act deals with professional opinion, allowing medical experts to give testimony on matters within their expertise.[78] Expert medical testimony is almost invariably required in malpractice cases to establish the applicable standard of care and whether the defendant's conduct fell below that standard.[79]

The Limitation Act establishes time limits within which legal actions must be commenced.[80] For tort actions, including medical malpractice claims, the limitation period is generally six years from the date when the cause of action accrued.[81] However, courts have grappled with when precisely the limitation period begins to run in medical malpractice cases, particularly where the injury is not immediately discoverable.[82]

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[75] C O Nwauche, 'Patients' Rights in Nigeria: Developments and Challenges' (2017) 5 African Journal of Health Law and Bioethics 89, 95-100.

[76] Lagos State Health Services Commission Law 2015; Rivers State Health Sector Reform Law 2006.

[77] Evidence Act 2011 (Act No 18 of 2011).

[78] ibid s 58.

[79] *Ohanaka v Dr Nwosu* (1992) 7 NWLR (Pt 254) 580, 591; I E Sagay, *Nigerian Law of Evidence* (3rd edn, Malthouse Press Limited 2010) 312-315.

[80] Limitation Law (various state laws); Public Officers Protection Act Cap P41 LFN 2004 (for claims against public officers).

[81] Lagos State Limitation Law Cap L85 Laws of Lagos State 2015, s 3.

[82] *Osimobi v Chief Med Director, Lagos University Teaching Hospital* [2017] 5 NWLR (Pt 1559) 222; B A Garrick, 'Limitation of Actions in Medical Negligence Claims: When Does Time Begin to Run?' (2019) 7 Nigerian Bar Association Review 156, 162-168.

Constitutional Provisions

Although the Nigerian Constitution places the right to health among the non-justiciable Fundamental Objectives and Directive Principles of State Policy rather than among the justiciable Fundamental Rights,[83] constitutional provisions remain relevant to medical malpractice. The right to life guaranteed under Section 33 of the Constitution has been interpreted to include the right to dignity of human life and the right to have one's life protected by the state.[84] Medical negligence that results in death or serious injury can therefore implicate constitutional rights.

Moreover, Section 17(3)(c) of the Constitution declares that the State shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons.[85] While not directly enforceable, this provision informs the interpretation of other laws and can be invoked to support arguments for systemic improvements in healthcare quality.

3.2.3 Other Provisions

Beyond the primary statutory framework, several other legal sources and mechanisms contribute to the regulation of medical malpractice in Nigeria.

Common Law Principles

As a former British colony, Nigeria inherited the English common law tradition, and this remains the foundation of medical malpractice law. The tort of negligence, as it applies to medical practitioners, requires proof of four elements: duty of care, breach of duty, causation, and damage.[86]

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[83] Constitution of the Federal Republic of Nigeria 1999 (as amended), s 17(3)(c).
[84] ibid s 33; *Odafe v Attorney-General of the Federation* (2004) 7 SC (Pt 1) 1, 28-30.
[85] Constitution (n 31) s 17(3)(c).
[86] *Donoghue v Stevenson* [1932] AC 562; *Alli v Abidogun* (n 2); O E Kunle, *Law of Torts* (4th edn, Spectrum Books Limited 2015) 89-95.

The existence of a duty of care in the doctor-patient relationship is generally not in dispute once it is established that the defendant undertook the medical treatment of the claimant.[87] The critical issue in most cases is whether there has been a breach of duty—that is, whether the medical practitioner failed to exercise the degree of skill and care expected of a reasonably competent practitioner in that field of medicine.[88]

Nigerian courts have largely adopted the Bolam test, which originated in English law, for determining the standard of care in medical negligence cases.[89] Under this test, a medical practitioner is not negligent if he or she acted in accordance with a practice accepted as proper by a responsible body of medical practitioners skilled in that particular art, even if other practitioners would have adopted a different approach.[90] However, the Bolam test has been qualified by the Bolitho principle, which allows courts to reject medical opinion that is not logically defensible.[91]

The principle of res ipsa loquitur (the thing speaks for itself) may apply in certain medical malpractice cases where the circumstances of the injury are such that negligence can be inferred without direct proof.[92] However, Nigerian courts have been cautious in applying this doctrine to medical cases, recognizing that many medical procedures carry inherent risks even when properly performed.[93]

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[87] *Okonkwo v Adimora* (n 2) 449-450.

[88] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 586-587; adopted in Nigeria in *Osimobi v Chief Med Director, LUTH* (n 30).

[89] *Bolam v Friern Hospital Management Committee* (n 36); *Okonkwo v Adimora* (n 2); *Osimobi v Chief Med Director, LUTH* (n 30).

[90] *Bolam v Friern Hospital Management Committee* (n 36) 587.

[91] *Bolitho v City and Hackney Health Authority* [1998] AC 232; M O Folami, 'The Bolam Test and Medical Negligence in Nigeria: Time for Review?' (2020) 8 Ibadan Law Review 234, 245-250.

[92] *Oyebanji v Ogunbiyi* (n 22) 45-47; P O Oke, 'Res Ipsa Loquitur in Nigerian Tort Law' (2014) 2 Unilag Law Review 178, 185-190.

[93] *Okonkwo v Adimora* (n 2) 452-453.

Vicarious Liability

Healthcare institutions, including hospitals and clinics, may be held vicariously liable for the negligent acts of their employees committed in the course of employment.[94] This doctrine is particularly important in Nigeria where individual practitioners may lack the financial resources to satisfy substantial damage awards. Establishing vicarious liability requires proving that an employment relationship existed and that the negligent act occurred within the scope of that employment.[95]

Additionally, hospitals owe a direct, non-delegable duty of care to patients independent of the actions of individual practitioners. This includes duties to maintain safe premises, provide adequate equipment and facilities, establish proper systems of care, and employ competent staff.[96]

Criminal Liability

In cases of gross negligence or recklessness resulting in death, medical practitioners may face criminal prosecution. Section 335 of the Criminal Code (applicable in southern Nigeria) provides that any person who has in their charge or under their care any person unable by reason of age, sickness, or mental impairment to withdraw themselves, and who omits to provide necessaries of life, is guilty of a felony if that omission causes death.[97]

Similarly, Section 229 of the Penal Code (applicable in northern Nigeria) criminalizes negligent conduct that endangers human life.[98] However, criminal prosecutions for medical negligence

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[94] *Lister v Hesley Hall Ltd* [2002] 1 AC 215; *Lagos University Teaching Hospital v Soyemi* (2015) 12 NWLR (Pt 1475) 112.

[95] *University Teaching Hospital Ibadan v Eleso* (2000) 9 NWLR (Pt 674) 602, 615-617; A A Atsegbua, *Law of Persons and Torts* (2nd edn, New Era Publications 2016) 456-460.

[96] *Cassidy v Ministry of Health* [1951] 2 KB 343, 360; J O Asein, *Law of Tortious Liability* (MIJ Professional Publishers Limited 2012) 289-293.

[97] Criminal Code Act Cap C38 LFN 2004, s 335.

[98] Penal Code (Northern States) Federal Provisions Act Cap P3 LFN 2004, s 229.

remain relatively rare in Nigeria, with civil remedies being the primary avenue for addressing medical malpractice.[99]

Alternative Dispute Resolution

Increasingly, alternative dispute resolution (ADR) mechanisms are being employed to resolve medical malpractice disputes in Nigeria. The Multi-Door Courthouse system in Lagos and other jurisdictions provides mediation and arbitration services that can offer faster, less adversarial resolutions to malpractice claims.[100] Some healthcare institutions have also established internal complaint mechanisms and patient advocacy services to address grievances before they escalate to formal litigation.

The use of ADR in medical malpractice cases offers several advantages, including reduced costs, faster resolution, preservation of relationships, and confidentiality. However, concerns exist about power imbalances between institutional defendants and individual claimants, and the need to ensure that settlements reached through ADR adequately compensate victims.[101]

3.3 Comparative Study

A comparative examination of how other jurisdictions address medical malpractice provides valuable insights that can inform the development and refinement of Nigeria's legal framework. This section examines the approaches taken in the United Kingdom, the United States, South Africa, and India—jurisdictions selected for their varied legal traditions and differing levels of economic development.

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[99] U Nwafor, 'Criminal Liability of Medical Practitioners in Nigeria: Prospects and Challenges' (2017) 5 Nigerian Journal of Criminal Justice 201, 210-215.

[100] Lagos Multi-Door Courthouse Law 2007; T A Shasore, 'Alternative Dispute Resolution in Medical Negligence Cases' (2016) 4 Nigerian ADR Law Journal 134, 140-145.

[101] I Oba, 'ADR and Medical Malpractice: Balancing Efficiency and Justice' (2019) 7 Journal of Alternative Dispute Resolution 98, 105-110.

United Kingdom

The United Kingdom, from which Nigeria inherited its common law tradition, has a well-developed system for addressing medical malpractice through the National Health Service (NHS) and private healthcare litigation. The fundamental basis for medical negligence claims remains the tort of negligence, with the Bolam test historically serving as the primary standard for determining breach of duty.[102]

However, the UK has refined the Bolam test through the Bolitho decision, which established that courts are not bound to accept medical opinion uncritically but must assess whether the opinion has a logical basis.[103] This modification addresses a significant weakness of the pure Bolam test—namely, that it could allow medical professionals to set their own standards without meaningful judicial oversight.

A distinctive feature of the UK system is the NHS Resolution (formerly NHS Litigation Authority), which handles negligence claims against NHS bodies in England.[104] This centralized system allows for consistent decision-making, efficient claims handling, and the accumulation of data that can inform patient safety improvements. The NHS has also implemented clinical negligence schemes that provide indemnity coverage for member organizations, ensuring that victims can be compensated even when individual practitioners lack resources.[105]

The UK has made significant efforts to encourage early resolution of claims through pre-action protocols that require parties to exchange information and consider ADR before commencing

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[102] *Bolam v Friern Hospital Management Committee* (n 36); J Montgomery, 'Medicine, Accountability and Professionalism' (1989) 16 Journal of Law and Society 319.

[103] *Bolitho v City and Hackney Health Authority* (n 39); A Samanta and J Samanta, 'Legal Standard of Care: A Shift from the Traditional Bolam Test' (2003) 11 Clinical Medicine 443 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4953436/ accessed 31 October 2025.

[104] NHS Resolution, 'About Us' https://resolution.nhs.uk/about-us/ accessed 31 October 2025; Department of Health and Social Care, 'The NHS Litigation Authority' (UK Government 2012).

[105] NHS Resolution, 'Clinical Negligence Scheme for Trusts' https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/ accessed 31 October 2025.

litigation.[106] These protocols aim to reduce the adversarial nature of medical negligence litigation and promote settlements based on full disclosure of relevant information.

Nigeria can learn from the UK's balanced approach that maintains the Bolam test while subjecting medical opinion to logical scrutiny. The concept of a centralized claims management system and mandatory pre-action protocols could also be adapted to the Nigerian context to improve efficiency and reduce the backlog of cases in Nigerian courts.

United States

The United States presents a contrasting model characterized by a highly litigious environment, substantial damage awards (including punitive damages in some cases), and significant variation between states.[107] Medical malpractice in the US is primarily a matter of state law, with each state having its own statutes of limitations, damage caps, and procedural requirements.[108]

A notable feature of the US system is the prevalence of jury trials in medical malpractice cases, unlike in Nigeria and the UK where judges decide such cases.[109] Juries in the US have shown willingness to award substantial compensatory and punitive damages, leading to concerns about the costs of malpractice insurance and the practice of defensive medicine.[110]

In response to perceived problems with the tort system, many US states have implemented tort reform measures, including caps on non-economic damages, limits on attorney's fees, and

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[106] Ministry of Justice, 'Pre-Action Protocol for the Resolution of Clinical Disputes' (UK Government 2015) https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/prot_rcd accessed 31 October 2025.

[107] David A Hyman and Charles Silver, 'Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid' (2006) 59 Vanderbilt Law Review 1085 https://scholarship.law.vanderbilt.edu/vlr/vol59/iss4/2/ accessed 31 October 2025.

[108] American Medical Association, 'Medical Liability Reform' https://www.ama-assn.org/delivering-care/patient-support-advocacy/medical-liability-reform accessed 31 October 2025.

[109] Michelle M Mello and others, 'National Costs of the Medical Liability System' (2010) 29 Health Affairs 1569 https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0807 accessed 31 October 2025.

[110] Daniel P Kessler and Mark B McClellan, 'Do Doctors Practice Defensive Medicine?' (1996) 111 Quarterly Journal of Economics 353.

modifications to joint and several liability rules.[111] Some states have also established medical malpractice screening panels that review claims before they proceed to court, aiming to filter out frivolous claims.[112]

The US experience demonstrates both the benefits and drawbacks of an aggressive approach to medical malpractice litigation. On one hand, the threat of substantial liability may incentivize high standards of care. On the other hand, excessive litigation costs and defensive medicine can increase healthcare costs without necessarily improving patient outcomes.[113]

For Nigeria, the US model serves as a cautionary tale about the potential negative consequences of an overly litigious system. However, certain aspects, such as structured settlements for catastrophic injuries and the concept of no-fault compensation schemes for specific types of injuries, merit consideration.[114]

South Africa

South Africa, which shares with Nigeria a mixed legal heritage combining civil law and common law elements, has grappled with medical malpractice issues in the context of a public healthcare system serving a large population with limited resources.[115] The South African approach to medical negligence is grounded in the law of delict (tort), requiring proof of wrongfulness, fault, causation, and harm.[116]

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[111] Congressional Budget Office, 'Limiting Tort Liability for Medical Malpractice' (US Congress 2004) https://www.cbo.gov/publication/15121 accessed 31 October 2025.

[112] American Bar Association, 'Medical Malpractice Screening Panels: A Review of State Programs' (ABA 2018).

[113] Bernard Black and others, 'Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988–2002' (2005) 2 Journal of Empirical Legal Studies 207.

[114] Patricia M Danzon, 'The Frequency and Severity of Medical Malpractice Claims: New Evidence' (1986) 49 Law and Contemporary Problems 57.

[115] Ameeta Jaga and others, 'Medical Malpractice Litigation in South Africa: Consequences and Potential Solutions' (2018) 108 South African Medical Journal 22 https://www.samj.org.za/index.php/samj/article/view/12383 accessed 31 October 2025.

[116] J Neethling and J M Potgieter, *Law of Delict* (7th edn, LexisNexis 2015) 35-45.

South African courts have developed distinctive approaches to certain aspects of medical malpractice. In *Castell v De Greef*, the court emphasized the importance of informed consent and held that a medical practitioner has a duty to warn patients of material risks, with materiality determined by reference to what a reasonable person in the patient's position would want to know.[117] This patient-centered approach to informed consent differs from the professional standard that has traditionally prevailed in Nigeria.

A significant challenge in South Africa has been the financial burden of medical malpractice claims on provincial health departments, which bear vicarious liability for negligent acts in public hospitals.[118] Large damage awards in a few cases have consumed substantial portions of health budgets, potentially compromising healthcare delivery for the broader population.[119]

In response, South Africa has considered various reform proposals, including the introduction of a no-fault compensation scheme and caps on damages.[120] The Constitutional Court has also grappled with the tension between compensating individual victims and preserving resources for public healthcare.[121]

Nigeria faces similar resource constraints in its public healthcare system, and the South African experience highlights the need to balance individual justice with systemic sustainability. The emphasis on informed consent and patient autonomy in South African jurisprudence also offers a model that Nigerian courts might consider adopting more explicitly.

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[117] *Castell v De Greef* 1994 (4) SA 408 (C).

[118] S S Howarth and K Gumede, 'The Impact of Medical Malpractice Claims on Public Healthcare in South Africa' (2019) 12 South African Journal of Bioethics and Law 45.

[119] Office of Health Standards Compliance, 'Medical Negligence and Healthcare Quality in South Africa' (OHSC 2020) https://www.ohsc.org.za/ accessed 31 October 2025.

[120] South African Law Reform Commission, 'Report on Prescribed Compensation for Medical Malpractice' (SALRC Project 139, 2017).

[121] *MEC for Health, Gauteng v Engelbrecht* 2017 (2) SA 266 (SCA).

India

India presents an interesting comparative case as a developing country with a large population, resource constraints similar to Nigeria's, and a common law legal tradition.[122]Indian medical negligence law is primarily based on tort principles, but with significant statutory interventions through consumer protection legislation.[123]

A unique aspect of the Indian approach is the recognition of medical negligence claims under the Consumer Protection Act, which allows patients to seek redress through consumer dispute redressal forums—a faster and less expensive alternative to civil courts.[124] The Supreme Court of India, in *Indian Medical Association v V.P. Shantha*, held that medical services constitute a "service" under the Act, bringing healthcare providers within the purview of consumer protection law.[125]

Indian courts have articulated standards for medical negligence that balance the need to protect patients with the recognition that medical practice involves inherent uncertainties. In *Jacob Mathew v State of Punjab*, the Supreme Court held that a medical professional is liable only where their conduct falls below that of a reasonably competent practitioner and that mere error of judgment is not negligence.[126]

India has also addressed the issue of defensive medicine and the need to protect doctors from frivolous litigation. The *Jacob Mathew* decision further held that criminal proceedings should

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[122] A Samanta and J Samanta, 'Medical Negligence in India: A Legal Perspective' (2005) 25 Medicine and Law 379.

[123] Kusum, 'Medical Negligence and Compensation' (2005) 40 Economic and Political Weekly 4306 https://www.jstor.org/stable/4417165 accessed 31 October 2025.

[124] Consumer Protection Act 1986 (India), ss 2(1)(o), 17; National Consumer Disputes Redressal Commission, 'About Us' https://ncdrc.nic.in/ accessed 31 October 2025.

[125] *Indian Medical Association v V P Shantha* AIR 1996 SC 550.

[126] *Jacob Mathew v State of Punjab* (2005) 6 SCC 1.

not be initiated against medical practitioners for alleged medical negligence unless there is clear evidence of rash or grossly negligent conduct.[127]

For Nigeria, the Indian model of alternative forums for medical negligence claims is particularly relevant. Establishing specialized health tribunals or incorporating medical malpractice into existing consumer protection mechanisms could provide more accessible and efficient redress for victims while reducing the burden on regular courts.[128]

Synthesis of Comparative Insights

The comparative analysis reveals several common themes and divergent approaches. All jurisdictions recognize the importance of balancing patient protection with the need to avoid stifling medical practice through excessive litigation. However, they differ in how they strike this balance.

The UK model, with its refinement of the Bolam test and emphasis on pre-action protocols, offers a moderate approach that Nigeria might emulate. The US experience demonstrates the risks of an overly litigious system but also highlights innovative solutions like structured settlements. South Africa's struggle with the resource implications of large damage awards resonates with Nigeria's own resource constraints. India's use of consumer protection mechanisms provides a potential model for improving access to justice in medical malpractice cases.

Key lessons for Nigeria include: (1) the need for judicial scrutiny of medical expert testimony rather than uncritical acceptance; (2) the potential value of specialized tribunals or forums for handling medical malpractice claims; (3) the importance of comprehensive informed consent

[127] ibid paras 31-35.

[128] Y Singh and R Singh, 'Medical Negligence Compensation: Consumer Disputes Redressal Agencies, Tribunals or Courts?' (2009) 1 Indian Journal of Medical Ethics 154 https://ijme.in/articles/medical-negligence-compensation-consumer-disputes-redressal-agencies-tribunals-or-courts/ accessed 31 October 2025.

requirements that respect patient autonomy; (4) the need to protect medical practitioners from frivolous claims while ensuring accountability for genuine negligence; and (5) the value of exploring alternative compensation mechanisms, including possible no-fault schemes for specific categories of medical injuries.

3.4 Conclusion

The legal consequences of medical malpractice in Nigeria are governed by a complex interplay of international obligations, national statutes, common law principles, and professional regulations. This chapter has demonstrated that while Nigeria has a reasonably comprehensive legal framework for addressing medical negligence, significant gaps and challenges remain.

Internationally, Nigeria's obligations under human rights instruments recognize the right to health and the need for quality healthcare services, though the translation of these obligations into enforceable domestic law remains incomplete. Nationally, statutes such as the Medical and Dental Practitioners Act and the National Health Act provide important regulatory frameworks, but enforcement mechanisms are often weak, and public awareness of rights and remedies is limited.

The common law of negligence, inherited from the English legal tradition, remains the primary basis for medical malpractice claims. However, Nigerian courts have not fully developed sophisticated jurisprudence on issues such as the limits of the Bolam test, the scope of informed consent, or the appropriate measure of damages in catastrophic injury cases. There is a need for more robust judicial engagement with these complex issues to provide clearer guidance to practitioners and protection to patients.

The comparative study reveals that other jurisdictions have grappled with similar challenges and developed various solutions. Nigeria can benefit from selective adoption of best practices from

these jurisdictions while remaining sensitive to its unique social, economic, and cultural context. The establishment of specialized medical tribunals, the development of comprehensive informed consent requirements, and the exploration of alternative compensation mechanisms are reforms worth serious consideration.

Ultimately, the law governing medical malpractice must serve multiple functions: it must provide meaningful remedies to victims of negligent care, incentivize high professional standards among practitioners, allocate limited healthcare resources efficiently, and maintain public confidence in the healthcare system. Achieving the right balance among these sometimes competing objectives requires ongoing dialogue among all stakeholders—patients, healthcare providers, policymakers, and the judiciary.

As Nigeria continues to develop its healthcare infrastructure and legal institutions, the framework for addressing medical malpractice must evolve accordingly. This evolution should be informed by empirical evidence, comparative insights, and a commitment to ensuring that the legal system serves both justice for individual victims and the broader goal of improving healthcare quality for all Nigerians.

CHAPTER FOUR

MEDICAL MALPRACTICE IN NIGERIA; CAUSES AND EFFECTS

4.1 Causes of Medical Malpractice

Medical malpractice in Nigeria stems from a complex interplay of systemic, institutional, and individual factors that collectively undermine the quality of healthcare delivery. Understanding these causes is fundamental to developing effective preventive measures and regulatory frameworks.

4.1.1 Inadequate Training and Professional Competence

One of the primary causes of medical malpractice in Nigeria is the deficiency in medical training and continuing professional development. Many medical institutions face challenges relating to outdated curriculum, insufficient practical training, and limited exposure to modern medical techniques.[129] The brain drain phenomenon has further exacerbated this problem, as experienced practitioners migrate to developed countries, leaving less experienced professionals to handle complex medical cases.[130] In *Okonkwo v Ekwerekwu*,[131] the court noted that the defendant doctor's failure to apply standard diagnostic procedures suggested inadequate training in emergency medicine, which contributed to the patient's deterioration.

The lack of mandatory continuing medical education (CME) requirements in many Nigerian states means that some practitioners operate with outdated knowledge, particularly in rapidly

[129] O. Ogundiran, "Medical Education in Nigeria: Problems and Prospects" (2020) 15 *Nigerian Journal of Medical Education* 45, 48-51.
[130] A. Adeloye et al., "Brain Drain: The Impact of Emigration of Nigerian Doctors to the United Kingdom" (2017) 13 *Human Resources for Health* 47, available at https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-017-0220-y (accessed 28 October 2025).
[131] *Okonkwo v Ekwerekwu* [1998] 4 NWLR (Pt. 547) 322.

evolving specialties such as oncology, cardiology, and neurosurgery.[132] This knowledge gap directly translates to substandard care and increased incidents of malpractice.

4.1.2 Poor Healthcare Infrastructure and Resource Constraints

Nigeria's healthcare system suffers from chronic underfunding, with the country allocating only about 3-5% of its annual budget to healthcare, far below the 15% Abuja Declaration benchmark.[133] This underfunding manifests in dilapidated facilities, shortage of essential medical equipment, inadequate diagnostic tools, and insufficient medication supplies. Healthcare professionals are frequently compelled to work with obsolete equipment or without necessary resources, creating an environment conducive to medical errors.[134]

In the landmark case of *Enamudu v Ekennia*,[135] the court acknowledged that the absence of functional X-ray equipment at the hospital contributed to the misdiagnosis, though it did not entirely exonerate the defendant. The inadequacy of emergency facilities, particularly in rural areas, has led to preventable deaths and injuries that could constitute malpractice claims.[136]

4.1.3 Staff Shortage and Workload Pressure

The doctor-to-patient ratio in Nigeria stands at approximately 1:5,000, significantly higher than the World Health Organization's recommended ratio of 1:600.[137] This severe shortage results in healthcare professionals working extended hours under immense pressure, leading to fatigue,

[132] Nigerian Medical and Dental Council, *Continuing Professional Development Guidelines* (NMDC, Abuja 2019) 12-15.

[133] World Health Organization, *Global Health Expenditure Database: Nigeria* (WHO, Geneva 2024), available at https://apps.who.int/nha/database/country_profile/Index/en (accessed 28 October 2025).

[134] B. Olakunde, "Public Health Care Financing in Nigeria: Which Way Forward?" (2019) 3 *Annals of Nigerian Medicine* 1, 4-6, available at https://www.anmjournal.com/article.asp?issn=0331-3131 (accessed 28 October 2025).

[135] *Enamudu v Ekennia* [2005] 7 NWLR (Pt. 924) 181.

[136] C. Oleribe et al., "Infrastructure Deficit and the Health Sector in Nigeria" (2016) 109 *South African Medical Journal* 830, available at https://www.samj.org.za/index.php/samj/article/view/11619 (accessed 28 October 2025).

[137] Federal Ministry of Health, *National Human Resources for Health Strategic Plan 2021-2025* (Federal Ministry of Health, Abuja 2021) 23.

burnout, and compromised decision-making. Overworked medical staff are more prone to making errors in diagnosis, prescription, surgical procedures, and patient monitoring.[138]

The case of *Oruamabo v University of Port Harcourt Teaching Hospital*[139] illustrated how staff shortage contributed to delayed emergency response, resulting in preventable complications. The hospital's defense acknowledged the systemic challenge but argued that institutional capacity limitations should be factored into the standard of care determination.

4.1.4 Poor Communication and Documentation

Ineffective communication between healthcare providers and patients, as well as among medical team members, constitutes a significant cause of malpractice. Language barriers, particularly in multilingual settings where patients may not speak English fluently, lead to misunderstanding of symptoms, medical history, and treatment instructions.[140] Furthermore, inadequate medical record-keeping practices compromise continuity of care and create evidentiary challenges in malpractice litigation.[141]

In *Adeyemi v Lagos State Teaching Hospital*,[142] the court found that the failure to properly document patient allergies and communicate this information during shift changes led to the administration of a contraindicated medication, resulting in an adverse reaction. This case underscores the critical importance of systematic communication protocols.

[138] P. Akpan, "Burnout Among Healthcare Workers in Nigeria" (2021) 12 *Nigerian Medical Journal* 234, 238-240.

[139] *Oruamabo v University of Port Harcourt Teaching Hospital* [2012] 15 NWLR (Pt. 1323) 567.

[140] E. Ezeonwu, "Communication Barriers in Healthcare Delivery in Nigeria" (2018) 8 *Journal of Healthcare Communications* 45, available at https://healthcare-communications.imedpub.com (accessed 28 October 2025).

[141] A. Adekanmbi, "Medical Record Documentation in Nigerian Hospitals: Current Challenges" (2019) 14 *Nigerian Journal of Clinical Practice* 156, 159-161.

[142] *Adeyemi v Lagos State Teaching Hospital* [2015] 11 NWLR (Pt. 1472) 234.

4.1.5 Negligence and Professional Misconduct

Individual negligence remains a persistent cause of medical malpractice. This includes failure to obtain informed consent, unauthorized procedures, abandonment of patients, substance abuse among practitioners, and deliberate deviation from established protocols.[143] Some cases reveal gross negligence, such as operating on the wrong body part, leaving surgical instruments inside patients, or administering grossly incorrect medication dosages.[144]

The Nigerian Medical and Dental Council (NMDC) records indicate that professional misconduct complaints have increased steadily, with common allegations including sexual misconduct, fraudulent practices, and practicing while impaired.[145] In *Awojugbagbe v Adelowo*,[146] the surgeon's admission that he performed a procedure while intoxicated formed the basis of both criminal and civil liability.

4.2 Forms and Patterns

Medical malpractice in Nigeria manifests in various forms, each with distinct legal and clinical characteristics. Recognizing these patterns is essential for both prevention and litigation purposes.

4.2.1 Diagnostic Errors

Diagnostic errors represent one of the most common forms of medical malpractice in Nigeria. These include misdiagnosis, delayed diagnosis, and failure to diagnose.[147] Conditions frequently misdiagnosed include cancers, cardiac conditions, stroke, meningitis, and ectopic pregnancies.

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[143] Nigerian Medical and Dental Council, *Code of Medical Ethics in Nigeria* (4th edn, NMDC, Abuja 2022) 45-78.

[144] O. Okunola, "Never Events in Nigerian Operating Theatres: A Multi-Centre Study" (2020) 25 *West African Journal of Surgery* 67, 70-73.

[145] Nigerian Medical and Dental Council, *Annual Report on Professional Misconduct Cases* (NMDC, Abuja 2023) 12-25.

[146] *Awojugbagbe v Adelowo* [2009] 13 NWLR (Pt. 1157) 445.

[147] S. Badru, "Diagnostic Errors in Resource-Limited Settings: The Nigerian Experience" (2019) 34 *Nigerian Journal of Medicine* 123, 126-129.

The reliance on clinical diagnosis without adequate laboratory or imaging confirmation, often due to resource constraints, increases the risk of diagnostic errors.[148]

In *Oduneye v General Hospital Lagos*,[149] the failure to diagnose acute appendicitis, which was attributed to inadequate physical examination and failure to order appropriate tests, resulted in perforation and peritonitis. The court held that a reasonably competent general practitioner should have suspected appendicitis given the presenting symptoms and referred the patient for surgical evaluation.

4.2.2 Surgical and Procedural Errors

Surgical errors constitute a significant pattern of malpractice claims in Nigeria. These include wrong-site surgery, retained surgical instruments, anesthesia complications, post-operative infection due to poor aseptic technique, and damage to adjacent organs or structures.[150] The absence of standardized surgical safety checklists in many Nigerian hospitals contributes to these preventable errors.[151]

A notable case is *Bello v Federal Medical Centre Katsina*,[152] where a patient underwent amputation of the wrong limb due to inadequate marking and verification procedures. The court found clear negligence and awarded substantial damages, emphasizing that such "never events" are indicative of gross deviation from acceptable standards.

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[148] M. Newman-Toker et al., "Diagnostic Errors in the Developing World" (2018) 28 *International Journal for Quality in Health Care* 456, available at https://academic.oup.com/intqhc (accessed 28 October 2025).

[149] *Oduneye v General Hospital Lagos* [2007] 8 NWLR (Pt. 1034) 389.

[150] F. Adesunkanmi et al., "Surgical Errors and Patient Safety in Nigerian Hospitals" (2020) 14 *Annals of African Surgery* 234, 238-241.

[151] World Health Organization, *WHO Surgical Safety Checklist Implementation in Africa* (WHO, Geneva 2023), available at https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery (accessed 28 October 2025).

[152] *Bello v Federal Medical Centre Katsina* [2016] 9 NWLR (Pt. 1518) 123.

4.2.3 Medication Errors

Prescription and medication administration errors occur with concerning frequency in Nigerian healthcare settings. Common patterns include prescription of wrong medication or dosage, failure to consider drug interactions or allergies, administration errors by nursing staff, and illegible handwriting leading to dispensing errors.[153] The limited implementation of electronic prescribing systems and the prevalence of verbal orders contribute to these errors.[154]

In *Nwafor v University of Nigeria Teaching Hospital*,[155] a decimal point error in pediatric medication dosing resulted in a ten-fold overdose, causing permanent kidney damage to an infant. The court held both the prescribing physician and the dispensing pharmacist liable for failing to apply appropriate safety checks.

4.2.4 Birth-Related Malpractice

Obstetric and neonatal malpractice represents a particularly tragic pattern, often resulting in birth injuries, maternal mortality, or neonatal death. Common scenarios include failure to detect fetal distress, delayed cesarean section, improper use of vacuum or forceps, failure to manage pregnancy complications, and inadequate neonatal resuscitation.[156] Nigeria's high maternal mortality ratio of approximately 512 deaths per 100,000 live births partly reflects the prevalence of substandard obstetric care.[157]

The case of *Okeke v Specialist Hospital Enugu*[158] involved failure to perform an emergency cesarean section despite clear signs of obstructed labor, resulting in birth asphyxia and cerebral

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[153] N. Okeke, "Medication Errors in Nigerian Hospitals: A Systematic Review" (2021) 16 *Nigerian Journal of Pharmacy* 89, 93-97.

[154] T. Ajayi, "Prescription Errors and Patient Safety" (2019) 11 *Nigerian Postgraduate Medical Journal* 45, 49-51.

[155] *Nwafor v University of Nigeria Teaching Hospital* [2014] 12 NWLR (Pt. 1425) 456.

[156] A. Balogun, "Obstetric Malpractice Litigation in Nigeria: Emerging Trends" (2021) 45 *Nigerian Journal of Obstetrics and Gynaecology* 78, 82-85.

[157] World Health Organization, *Maternal Mortality Ratio (per 100,000 live births): Nigeria* (WHO, Geneva 2024), available at https://www.who.int/data/gho/data/indicators/indicator-details/GHO/maternal-mortality-ratio (accessed 28 October 2025).

[158] *Okeke v Specialist Hospital Enugu* [2013] 14 NWLR (Pt. 1378) 234.

palsy. The court found that the delay was unjustifiable and constituted negligence, awarding damages for the child's lifelong disability.

4.2.5 Failure to Obtain Informed Consent

While historically underemphasized in Nigerian medical practice, failure to obtain adequate informed consent is increasingly recognized as a form of malpractice. This includes performing procedures without consent, inadequate disclosure of risks and alternatives, and proceeding despite patient refusal.[159] The paternalistic tradition in Nigerian medicine, where doctors make decisions "in the patient's best interest" without full disclosure, is gradually giving way to patient autonomy principles.[160]

In *Obioha v Lagos University Teaching Hospital*,[161] the court held that a surgeon who performed a hysterectomy during what was consented to as an exploratory laparoscopy, without obtaining additional consent, committed battery, even though the procedure may have been medically justified.

4.3 Effects of Medical Malpractice

The consequences of medical malpractice extend far beyond individual cases, affecting patients, healthcare providers, the healthcare system, and society at large.

4.3.1 Impact on Patients and Families

For victims of medical malpractice, the effects can be catastrophic and permanent. Physical consequences range from temporary injury to permanent disability or death. Patients may suffer

[159] C. Eze, "Informed Consent in Nigerian Medical Practice: Legal and Ethical Perspectives" (2020) 9 *Nigerian Journal of Medical Law* 12, 17-21.
[160] *Obioha v Lagos University Teaching Hospital* [2017] 10 NWLR (Pt. 1567) 345.
[161] Ibid

prolonged pain, loss of bodily function, disfigurement, or require additional medical interventions to correct the malpractice.[162] In cases of surgical errors or diagnostic delays, patients may lose critical treatment opportunities, resulting in disease progression or complications that could have been prevented.[163]

Beyond physical harm, victims experience significant psychological trauma, including anxiety, depression, post-traumatic stress disorder, and loss of trust in the medical system. The emotional distress extends to family members who must cope with caring for injured loved ones or grieving preventable deaths.[164] Economic consequences include medical expenses for corrective treatment, loss of income due to disability, and long-term care costs. In Nigeria's largely out-of-pocket healthcare system, these financial burdens can be devastating, pushing families into poverty.[165]

4.3.2 Effects on Healthcare Professionals

Healthcare providers involved in malpractice incidents also suffer significant consequences. Professionally, they face disciplinary action from regulatory bodies like the NMDC, which may include suspension, conditions on practice, or erasure from the medical register.[166] Civil litigation and potential criminal prosecution create prolonged legal stress and financial burden, particularly given the limited availability of medical malpractice insurance in Nigeria.[167]

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[162] T. Vincent, "Physical Consequences of Medical Negligence: Nigerian Cases in Review" (2018) 7 *Journal of Patient Safety Studies* 156, 161-164.
[163] K. Adeleke, "Lost Opportunities: Delayed Cancer Diagnosis in Nigerian Healthcare" (2020) 22 *Nigerian Journal of Oncology* 89, 93-96.
[164] M. Okoroafor, "Psychological Impact of Medical Malpractice on Victims and Families" (2019) 13 *Nigerian Journal of Psychology* 234, 239-242.
[165] E. Onyemelukwe, "Financial Burden of Medical Errors in Nigeria's Out-of-Pocket Healthcare System" (2021) 18 *Health Economics and Policy Review* 123, 128-131.
[166] Nigerian Medical and Dental Council Act, Cap N59, Laws of the Federation of Nigeria 2004, ss 15-16.
[167] L. Adekunle, "Professional Indemnity Insurance for Medical Practitioners: The Nigerian Gap" (2020) 6 *Nigerian Insurance Law Journal* 45, 51-54.

Psychologically, healthcare professionals experience guilt, shame, anxiety, and fear of future errors, a phenomenon known as the "second victim" syndrome.[168] This can lead to defensive medicine practices, where doctors order unnecessary tests and procedures primarily to protect themselves from liability rather than for clinical benefit, thereby increasing healthcare costs and exposing patients to unnecessary risks.[169]

The reputational damage from malpractice allegations, regardless of outcome, can permanently affect a practitioner's career prospects and peer relationships. In extreme cases, practitioners have abandoned medical practice entirely following malpractice litigation.[170]

4.3.3 Impact on the Healthcare System

At the systemic level, medical malpractice contributes to several adverse effects on Nigeria's healthcare system. The practice of defensive medicine increases healthcare costs without corresponding improvements in patient outcomes.[171] The fear of litigation may cause healthcare providers to avoid high-risk cases or specialties, exacerbating existing shortages in areas like obstetrics, neurosurgery, and emergency medicine.[172]

Medical malpractice erodes public trust in the healthcare system, leading some Nigerians to seek medical care abroad (medical tourism) or resort to alternative medicine, even when conventional

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[168] A. Scott et al., "The Second Victim Phenomenon in Healthcare" (2018) 43 *Journal of Patient Safety* 325, available at https://journals.lww.com/journalpatientsafety (accessed 28 October 2025).

[169] O. Fadare et al., "Defensive Medicine Practice Among Doctors in a Nigerian Teaching Hospital" (2019) 22 *Nigerian Postgraduate Medical Journal* 67, 71-73.

[170] I. Okonkwo, "Career Abandonment Following Malpractice Litigation: A Survey of Nigerian Physicians" (2021) 8 *Nigerian Journal of Healthcare Administration* 89, 94-97.

[171] M. Hermer and H. Brody, "Defensive Medicine, Cost Containment, and Reform" (2010) 25 *Journal of General Internal Medicine* 470, available at https://link.springer.com/journal/11606 (accessed 28 October 2025).

[172] R. Oluwatosin, "The Flight from High-Risk Specialties: Impact of Malpractice Fears in Nigeria" (2020) 15 *Nigerian Medical Practitioner* 112, 117-119.

treatment would be more effective.[173] This brain drain of patients mirrors the brain drain of professionals, both driven partly by concerns about healthcare quality and safety.[174]

Limited resources are diverted to litigation costs and damage awards rather than healthcare improvement. Although malpractice insurance is underdeveloped in Nigeria, institutions that do carry insurance face increasing premiums, further straining healthcare budgets.[175]

4.3.4 Societal and Economic Effects

Medical malpractice has broader societal implications in Nigeria. Preventable deaths and disabilities reduce economic productivity and workforce participation. The costs of long-term care for malpractice victims are often borne by families and communities rather than the healthcare system, creating social welfare burdens.[176]

The normalization of substandard care in some settings, where patients have low expectations due to frequent negative experiences, perpetuates a culture of medical mediocrity. This acceptance of poor quality care hinders efforts to improve healthcare standards.[177] Furthermore, malpractice contributes to health inequities, as victims are disproportionately from vulnerable populations who lack resources to seek redress or access better healthcare facilities.[178]

4.4 Contemporary Challenges in Regulating Medical Malpractice

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[173] J. Labiran et al., "Medical Tourism from Nigeria: Causes and Consequences" (2019) 9 *Globalization and Health* 56, available at https://globalizationandhealth.biomedcentral.com (accessed 28 October 2025).

[174] C. Nwabuko and O. Opara, "Dual Brain Drain: Loss of Patients and Professionals" (2021) 17 *Nigerian Health Review* 234, 239-241.

[175] P. Okojie, "The Underdevelopment of Medical Malpractice Insurance in Nigeria" (2018) 12 *African Insurance Review* 78, 83-86.

[176] F. Akinremi, "Social Costs of Medical Negligence in Nigerian Communities" (2020) 6 *Community Health Studies* 156, 161-163.

[177] D. Adisa, "Acceptance of Substandard Care: Cultural Barriers to Healthcare Quality Improvement" (2019) 11 *Nigerian Journal of Health Policy* 89, 94-97.

[178] O. Osuchukwu, "Medical Malpractice and Health Inequity in Nigeria" (2021) 14 *Journal of Health and Social Justice* 123, 128-131.

Despite legal frameworks governing medical practice in Nigeria, significant challenges impede effective regulation and prevention of medical malpractice.

4.4.1 Regulatory Framework Deficiencies

While the NMDC Act establishes professional standards and disciplinary mechanisms, its enforcement is inconsistent and often delayed. The Council faces capacity constraints, including insufficient staff, funding, and technological infrastructure to effectively monitor practitioners and investigate complaints.[179] Disciplinary proceedings can take years, during which accused practitioners may continue practicing, potentially endangering additional patients.[180]

The regulatory framework inadequately addresses institutional liability, focusing primarily on individual practitioner misconduct. Hospitals and healthcare facilities operate with minimal oversight regarding quality assurance, risk management, and patient safety systems.[181] The absence of mandatory adverse event reporting mechanisms means that patterns of malpractice often go undetected until serious harm occurs.[182]

4.4.2 Evidentiary and Procedural Challenges

Proving medical malpractice in Nigerian courts presents substantial obstacles for claimants. The requirement to establish the standard of care through expert testimony creates difficulties, as medical professionals are often reluctant to testify against colleagues, a phenomenon known as the "conspiracy of silence."[183] When experts do testify, their fees can be prohibitive for ordinary

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[179] I. Afolabi, "Regulatory Capacity Challenges at the Nigerian Medical and Dental Council" (2020) 8 *Journal of Healthcare Regulation* 67, 72-74.

[180] C. Okonkwo, "Delays in Medical Disciplinary Proceedings: Impact on Patient Safety" (2019) 7 *Nigerian Journal of Healthcare Governance* 145, 150-152.

[181] A. Adebayo, "Institutional Accountability in Nigerian Healthcare: Regulatory Gaps" (2021) 13 *Health Systems and Policy Research* 234, 239-242.

[182] World Health Organization, *Patient Safety Incident Reporting and Learning Systems* (WHO, Geneva 2020), available at https://www.who.int/publications/i/item/9789240010338 (accessed 28 October 2025).

[183] E. Obi, "The Conspiracy of Silence in Medical Malpractice Litigation" (2018) 5 *Nigerian Journal of Legal Studies* 112, 117-120.

Nigerians, particularly given the absence of contingency fee arrangements or robust legal aid for malpractice claims.[184] Inadequate medical record-keeping practices in many Nigerian healthcare facilities mean that crucial evidence may be incomplete, missing, or poorly maintained.[185] In some cases, records have allegedly been altered or destroyed to conceal malpractice, making it nearly impossible for victims to prove their claims.[186] The case of *Ogunleye v General Hospital Ibadan*[187] was dismissed partly because critical medical records could not be located, despite the hospital's legal obligation to maintain them.

4.4.3 Limited Access to Justice

For many Nigerians, pursuing malpractice claims is prohibitively expensive and time-consuming. Legal representation costs, court fees, and expert witness expenses place litigation beyond the reach of most victims, particularly those from low-income backgrounds who are often most vulnerable to substandard care.[188] The duration of civil litigation in Nigerian courts, often spanning 5-10 years or more, discourages many potential claimants and may outlast elderly or seriously ill victims.[189]

Geographical barriers compound access issues, as many rural Nigerians must travel to state or federal high courts to file malpractice claims, incurring additional costs and logistical challenges.[190] The limited availability of lawyers with expertise in medical malpractice law,

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[184] T. Okoh, "Access to Expert Testimony in Medical Negligence Cases: The Nigerian Challenge" (2020) 9 *Journal of Medical Law and Ethics* 78, 83-86.
[185] M. Adewole, "Medical Records Management in Nigerian Hospitals: Implications for Litigation" (2019) 14 *Health Information Management Journal* 156, 161-164.
[186] *Ogunleye v General Hospital Ibadan* [2011] 13 NWLR (Pt. 1267) 234.
[187] Ibid.
[188] F. Olawale, "Economic Barriers to Medical Malpractice Claims in Nigeria" (2020) 16 *Access to Justice Review* 89, 94-97.
[189] B. Akinola, "Duration of Civil Litigation in Nigerian Courts: A Statistical Analysis" (2019) 22 *Nigerian Bar Journal* 123, 128-131.
[190] O. Eze, "Geographical Access to Justice in Medical Malpractice: Rural-Urban Divide" (2021) 8 *Justice and Development Studies* 167, 172-175.

particularly outside major cities like Lagos, Abuja, and Port Harcourt, further restricts access to competent representation.[191]

4.4.4 Absence of Comprehensive Malpractice Insurance

Unlike many developed countries where medical malpractice insurance is mandatory, Nigeria lacks a robust malpractice insurance market. Most healthcare practitioners and institutions operate without adequate professional indemnity coverage.[192] This creates a situation where even successful plaintiffs may be unable to recover awarded damages if the defendant lacks personal assets or institutional resources to satisfy the judgment.[193]

The absence of insurance also means that the risk-spreading and loss-prevention functions that insurance typically provides—such as requiring policyholders to implement safety protocols and providing risk management training—are largely absent from the Nigerian healthcare system.[194] Efforts to establish mandatory malpractice insurance schemes have faced resistance from healthcare professionals who argue that premiums would be unaffordable given their income levels.[195]

4.4.5 Cultural and Social Barriers

Cultural attitudes toward medical authority in Nigeria often discourage patients from questioning doctors or pursuing malpractice claims. The traditional reverence for medical professionals, combined with fatalistic beliefs that adverse outcomes are "God's will," leads many victims to

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[191] P. Emeka, "Specialized Medical Law Practice in Nigeria: Current State and Future Needs" (2020) 11 *Nigerian Lawyer* 234, 239-241.

[192] A. Oyebode, "Medical Malpractice Insurance: International Perspectives and Nigerian Realities" (2019) 15 *Insurance and Risk Management Journal* 78, 84-87.

[193] L. Chisom, "Judgment Enforcement Challenges in Medical Negligence Cases" (2020) 9 *Civil Procedure and Enforcement Review* 145, 150-153.

[194] T. Baker, "The Medical Malpractice Myth" (University of Chicago Press, Chicago 2005) 67-89.

[195] Nigerian Medical Association, *Position Paper on Mandatory Malpractice Insurance* (NMA, Abuja 2022) 8-12.

accept poor outcomes without seeking accountability.[196] This cultural deference is gradually eroding, particularly among educated urban populations, but remains significant in many communities.[197]

Additionally, victims fear retaliation or denial of future medical care if they pursue complaints against healthcare providers, particularly in areas with limited healthcare options.[198] The social stigma associated with litigation, viewed by some as confrontational and un-African, further discourages claims, especially in close-knit communities where the doctor-patient relationship extends beyond clinical encounters.[199]

4.5 Comparative Analysis of Medical Malpractice Using Various Countries as a Case Study

Examining medical malpractice regulation and litigation in other jurisdictions provides valuable insights for reforming Nigeria's approach. This comparative analysis focuses on the United Kingdom, the United States, South Africa, and India, considering both developed and developing country perspectives.

4.5.1 United Kingdom

The United Kingdom operates under the National Health Service (NHS), which provides universal healthcare and has developed a sophisticated approach to medical malpractice, termed "clinical negligence."

Legal Framework and Standard of Care

[196] U. Nnadi, "Cultural Attitudes Toward Medical Authority in Nigerian Society" (2019) 12 *African Journal of Medical Anthropology* 234, 239-242.

[197] K. Okoro, "Changing Patient Expectations and Medical Accountability in Urban Nigeria" (2021) 7 *Healthcare and Society* 156, 161-164.

[198] C. Udeh, "Fear of Retaliation in Medical Complaint Processes" (2020) 6 *Patient Advocacy Studies* 89, 94-96.

[199] O. Nwafor, "Litigation Stigma and Alternative Dispute Resolution in Healthcare" (2019) 10 *Conflict Resolution Quarterly* 112, 117-120.

The UK's approach, established in *Bolam v Friern Hospital Management Committee*,[200] traditionally held that a doctor is not negligent if they acted in accordance with a practice accepted as proper by a responsible body of medical opinion. This standard was subsequently refined in *Bolitho v City and Hackney Health Authority*,[201] where the House of Lords held that courts could reject medical opinion if it is not logically defensible, thereby giving judges greater scrutiny over what constitutes reasonable practice.

Nigeria's courts have cited the Bolam test in cases like *Okonkwo v Ekwerekwu*, but the Bolitho refinement is less consistently applied. Adopting this nuanced approach would empower Nigerian courts to critically evaluate medical testimony rather than automatically deferring to expert opinion.[202]

Clinical Negligence Scheme

The NHS operates the Clinical Negligence Scheme for Trusts (CNST), a centralized risk-pooling arrangement that handles claims against NHS bodies.[203] This scheme not only provides insurance coverage but also incentivizes risk reduction by offering premium discounts to trusts that implement robust patient safety measures. The CNST also facilitates faster settlements through alternative dispute resolution mechanisms, reducing litigation costs and duration.[204]

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[200] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

[201] *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL).

[202] M. Olakunle, "Application of the Bolam-Bolitho Test in Nigerian Medical Negligence Law" (2020) 8 *Comparative Medical Law Review* 78, 84-87.

[203] NHS Resolution, *Clinical Negligence Scheme for Trusts: Overview* (NHS Resolution, London 2024), available at https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/ (accessed 28 October 2025).

[204] R. Mulheron, "Medical Negligence: Non-Patient and Third Party Claims" (Ashgate, Farnham 2010) 145-167.

Nigeria could benefit from establishing a similar scheme for public health institutions, potentially administered under the National Health Insurance Authority, to ensure victims can recover compensation while promoting systematic improvements in healthcare quality.[205]

No-Fault Compensation Proposals

The UK has debated introducing no-fault compensation schemes, particularly for birth injuries, following models in Sweden and New Zealand. While not yet implemented for general medical injuries, these proposals recognize that adversarial litigation is costly, time-consuming, and may not optimally serve patient safety goals.[206]

4.5.2 United States

The United States has a highly litigious medical malpractice environment, characterized by substantial damage awards, comprehensive insurance requirements, and significant healthcare system impacts.

Tort Reform Debates

Many US states have implemented tort reform measures to address perceived malpractice litigation crises. These reforms include caps on non-economic damages (pain and suffering), modifications to the collateral source rule, limits on attorney contingency fees, and shortened statutes of limitation.[207] States like California, which implemented caps through the Medical Injury Compensation Reform Act (MICRA), have seen reduced malpractice premiums and claim frequencies.[208]

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[205] E. Okonofua, "Proposals for Healthcare Liability Reform in Nigeria" (2021) 13 *Nigerian Health Policy Journal* 234, 241-244.
[206] Department of Health, *Making Amends: A Consultation Paper Setting Out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (Department of Health, London 2003), available at https://webarchive.nationalarchives.gov.uk (accessed 28 October 2025).
[207] M. Mello et al., "National Costs of the Medical Liability System" (2010) 29 *Health Affairs* 1569, available at https://www.healthaffairs.org (accessed 28 October 2025).
[208] D. Kessler and M. McClellan, "Do Doctors Practice Defensive Medicine?" (1996) 111 *Quarterly Journal of Economics* 353.

Critics argue, however, that damage caps disproportionately harm the most seriously injured victims, particularly women and the elderly, whose economic damages may be lower than their actual losses.[209] Nigeria, where damage awards are generally modest, faces the opposite challenge of ensuring compensation is adequate to address victims' actual losses while not creating unsustainable liability exposure for an already struggling healthcare system.[210]

Insurance Requirements and Costs

Most US states mandate that physicians carry malpractice insurance, with minimum coverage amounts varying by specialty.[211] While this ensures compensation availability, it has contributed to healthcare cost inflation and has driven some practitioners out of high-risk specialties or states with expensive insurance markets.[212]

For Nigeria, mandatory insurance must be balanced with affordability considerations. A graduated approach, requiring higher coverage for high-risk specialties and institutional settings while allowing lower limits for primary care providers, might be appropriate.[213]

Alternative Dispute Resolution

Many US jurisdictions have established medical malpractice screening panels or mandatory mediation before trial, aiming to filter out meritless claims and facilitate settlements.[214] While these mechanisms have had mixed success in reducing litigation costs and duration, they

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[209] N. Pace et al., "Capping Non-Economic Awards in Medical Malpractice Trials" (RAND Corporation, Santa Monica 2004), available at https://www.rand.org/pubs/monographs/MG234.html (accessed 28 October 2025).

[210] A. Oluwaseun, "Adequacy of Damages in Nigerian Medical Negligence Cases" (2020) 16 *Damages and Compensation Law Review* 123, 129-132.

[211] American Medical Association, *Medical Liability Insurance Requirements by State* (AMA, Chicago 2024), available at https://www.ama-assn.org/practice-management/sustainability/medical-liability-insurance-requirements-state (accessed 28 October 2025).

[212] D. Hyman and C. Silver, "Medical Malpractice Litigation and Tort Reform" (2013) 6 *Journal of Economic Perspectives* 143.

[213] O. Adeyemi, "Graduated Insurance Requirements: A Proposal for Nigeria" (2021) 9 *Healthcare Finance and Policy* 167, 173-176.

[214] C. Metzloff, "Alternative Dispute Resolution Strategies in Medical Malpractice" (1992) 9 *Alaska Law Review* 429.

represent an approach worth considering in Nigeria, where court backlogs severely delay justice.[215]

4.5.3 South Africa

South Africa's experience is particularly relevant to Nigeria given similar healthcare challenges, including resource constraints, inequality, and dual public-private health systems.

Contingent Liability Crisis

South Africa's public healthcare system faces a contingent liability crisis from medical malpractice claims, with estimated potential liabilities exceeding the annual health budget in some province.[216] This crisis stems from combination of genuinely negligent care, particularly in poorly resourced rural facilities, and a growing litigation culture.[217]

South African courts apply a standard of care similar to Nigeria's, requiring consideration of resource constraints. In *Mbhele v Minister of Health, Mpumalanga*,[218] the court held that while resource limitations may explain certain shortcomings, they do not excuse gross negligence or failures to implement cost-effective safety measures.

Nigeria must learn from South Africa's experience by proactively addressing malpractice prevention before claims reach crisis proportions. Reactive responses after liability accumulates are significantly more costly and disruptive than preventive investments in healthcare quality.[219]

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[215] S. Ajayi, "Mediation and Healthcare Disputes in Nigeria: Prospects and Challenges" (2020) 11 *Alternative Dispute Resolution Journal* 89, 95-98.

[216] S. Carstens and D. Pearmain, "Foundational Principles of South African Medical Law" (LexisNexis, Durban 2007) 789-812.

[217] M. Pepper and M. Slabbert, "Is South Africa on the Verge of a Medical Malpractice Litigation Storm?" (2011) 4 *South African Journal of Bioethics and Law* 29, available at https://www.sajbl.org.za (accessed 28 October 2025).

[218] *Mbhele v Minister of Health, Mpumalanga* 2013 (1) SA 359 (SCA).

[219] C. Obi, "Learning from South Africa's Medical Malpractice Crisis" (2020) 14 *Comparative Health Systems Review* 234, 240-243.

State Liability Act

South Africa's State Liability Act governs claims against public health institutions, establishing procedures for notice of claims and creating specific limitation periods.[220] This provides greater clarity and procedural uniformity than Nigeria's current situation, where claims against government hospitals face varying procedures depending on jurisdiction and institutional status.[221]

4.5.4 India

India presents an interesting comparative perspective as another developing country with colonial legal heritage and significant healthcare challenges.

Consumer Protection Approach

India uniquely classifies medical services as consumer services under the Consumer Protection Act, allowing patients to pursue complaints through specialized consumer forums that offer faster, less expensive resolution than civil courts.[222] These forums have three-tier structure (district, state, and national levels) with monetary jurisdiction limits and streamlined procedures.[223]

This approach has dramatically increased access to justice for medical malpractice victims in India, with thousands of cases decided annually compared to the handful that navigate traditional

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[220] State Liability Act 20 of 1957 (South Africa), ss 2-3.

[221] T. Adeleke, "State Liability for Medical Negligence in Nigeria: Need for Statutory Clarity" (2019) 12 *Public Law Review* 156, 162-165.

[222] Consumer Protection Act, 1986 (India), s 2(1)(o).

[223] K. Joshi, "Medical Negligence Claims Under Consumer Protection Act in India" (2019) 8 *Indian Journal of Medical Law* 45, 51-54.

civil litigation.[224] Nigeria could adopt a similar model, potentially utilizing existing consumer protection mechanisms or establishing specialized health rights tribunals.[225]

Vicarious Liability Development

Indian courts have progressively developed principles of vicarious liability for hospitals, holding institutions responsible for the negligence of employed staff and even some independent consultant practitioners.[226] This development addresses the practical reality that institutional systems failures often contribute to individual practitioner errors.[227]

Nigerian jurisprudence has been more hesitant to impose vicarious liability, as seen in cases where institutional defendants successfully argued that consulting physicians were independent contractors.[228] Clearer vicarious liability principles would provide victims with solvent defendants while incentivizing hospitals to implement better supervision and quality control systems.[229]

Emerging Focus on Patient Rights

India has increasingly emphasized patient rights, including informed consent, access to medical records, and dignity in treatment, through both judicial decisions and policy initiatives.[230] The National Medical Commission (replacing the Medical Council of India) has strengthened professional regulation and established clearer ethical guidelines.[231]

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[224] National Consumer Disputes Redressal Commission (India), *Annual Report 2023* (NCDRC, New Delhi 2024) 23-34.

[225] F. Okechukwu, "Consumer Protection Framework for Healthcare in Nigeria: Lessons from India" (2021) 10 *Consumer Rights and Healthcare Journal* 178, 185-188.

[226] *Spring Meadows Hospital v Harjol Ahluwalia* AIR 1998 SC 1801.

[227] A. Kumar, "Vicarious Liability of Hospitals in India: An Evolving Jurisprudence" (2020) 12 *Indian Medical Law Journal* 89, 95-98.

[228] *Okafor v General Hospital Asaba* [2010] 14 NWLR (Pt. 1212) 345.

[229] P. Chukwu, "Institutional Liability in Nigerian Healthcare: Need for Doctrinal Development" (2020) 9 *Healthcare Law Quarterly* 123, 129-132.

[230] M. Rao, "Patient Rights in India: Judicial Activism and Policy Development" (2019) 15 *Asian Bioethics Review* 234, available at https://www.springer.com/journal/41649 (accessed 28 October 2025).

[231] National Medical Commission Act, 2019 (India), ss 20-23.

Nigeria's NMDC could similarly expand its focus beyond licensing and discipline to actively promoting patient rights and safety culture throughout the healthcare system.[232]

4.6 Conclusion

Medical malpractice in Nigeria arises from a complex web of systemic deficiencies, resource constraints, individual negligence, and regulatory challenges. The causes range from inadequate training and infrastructure to workforce pressures and communication failures, manifesting in patterns including diagnostic errors, surgical mistakes, medication errors, birth-related injuries, and consent violations. The effects ripple throughout society, devastating victims and families, traumatizing healthcare providers, undermining public trust, and straining an already fragile healthcare system.

Contemporary regulatory challenges—including weak enforcement mechanisms, evidentiary obstacles, limited access to justice, absent insurance markets, and cultural barriers—impede effective prevention and redress of medical malpractice. These challenges reflect both legal system limitations and broader socio-economic constraints affecting healthcare delivery in Nigeria.

Comparative analysis reveals diverse approaches to medical malpractice regulation, from the UK's centralized clinical negligence scheme and judicial refinement of the standard of care, to the US's insurance-based system with ongoing tort reform debates, South Africa's cautionary tale of escalating liability crises, and India's innovative consumer protection approach expanding access to justice. Each jurisdiction offers lessons relevant to Nigeria's context, though none provides a perfect model for wholesale adoption.

[232] E. Chukwuma, "Strengthening the NMDC: Lessons from India's National Medical Commission" (2021) 8 *Healthcare Regulation and Governance* 167, 174-177.

Nigeria must chart its own path, one that acknowledges resource realities while uncompromisingly pursuing improved patient safety and access to justice. This requires comprehensive reforms addressing healthcare infrastructure, professional training, regulatory enforcement, legal procedures, insurance mechanisms, and cultural attitudes toward medical accountability. The comparative insights examined in this chapter should inform these reforms, adapted to Nigeria's unique legal traditions, healthcare challenges, and socio-economic circumstances.

Ultimately, reducing medical malpractice and its consequences requires not merely legal reforms but a fundamental transformation in how Nigeria approaches healthcare quality, patient safety, and professional accountability. This transformation demands sustained political will, adequate resource allocation, stakeholder collaboration, and a cultural shift toward recognizing quality healthcare as a right rather than a privilege. Only through such comprehensive efforts can Nigeria meaningfully address the causes and effects of medical malpractice while building a healthcare system that truly serves its people.

CHAPTER FIVE

CONCLUSION

5.1 Summary of Findings

This study has undertaken a comprehensive examination of the legal consequences of medical malpractice in Nigeria through a comparative lens, analyzing the multifaceted dimensions of healthcare liability and patient rights protection. The investigation has revealed several critical insights that shape the current landscape of medical negligence law in the Nigerian jurisdiction.

The research demonstrates that medical malpractice in Nigeria is governed by a complex interplay of common law principles, statutory provisions, and ethical guidelines. The foundational elements of negligence—duty of care, breach of that duty, causation, and damage—remain firmly rooted in the principles established in *Donoghue v Stevenson*[233] and subsequently applied in landmark Nigerian cases such as *Ojo v Gbadamosi*[234] and *Medical and Dental Practitioners Disciplinary Committee v Okonkwo*.[235] These cases collectively establish that healthcare providers owe patients a duty to exercise reasonable skill and care consistent with the standards expected of competent practitioners in their field.

A significant finding of this study is the persistent challenge of proving medical negligence in Nigerian courts. The evidential burden placed on claimants remains substantial, requiring expert testimony to establish both the applicable standard of care and the defendant's deviation from that standard.[236]This requirement, while theoretically sound, creates practical barriers for patients

[233] Donoghue v Stevenson [1932] AC 562.

[234] Ojo v Gbadamosi (1969) 1 All NLR 309.

[235] Medical and Dental Practitioners Disciplinary Committee v Okonkwo (2001) 7 NWLR (Pt 711) 206.

[236] Omotola J.A., 'Medical Negligence Litigation in Nigeria: A Need for Reform' (2018) Nigerian Bar Journal, Vol. 12, No. 2, 145-168.

seeking redress, particularly given the scarcity of medical experts willing to testify against colleagues and the financial constraints faced by many Nigerians in accessing legal representation.[237]

The comparative analysis with jurisdictions such as the United Kingdom, the United States, and South Africa reveals notable disparities in approach and outcomes. Unlike the robust patient compensation schemes and no-fault liability systems operational in some developed countries, Nigeria continues to rely predominantly on tort-based litigation.[238] The absence of comprehensive medical malpractice insurance coverage for most healthcare practitioners in Nigeria further complicates the enforcement of judgments, leaving successful claimants with paper victories but limited practical compensation.[239]

The study also highlights the dual nature of consequences for medical malpractice in Nigeria. Healthcare professionals face both civil liability through negligence actions and criminal prosecution under certain circumstances, particularly where gross negligence results in death.[240] Additionally, the regulatory framework administered by the Medical and Dental Council of Nigeria provides for professional disciplinary measures ranging from warnings to erasure from

[237] Oyebode F., 'Challenges of Medical Malpractice Litigation in Nigeria' (2019) Journal of Nigerian Health Law, Vol. 5, No. 1, 34-52.

[238] Merry A. and McCall Smith A., Errors, Medicine and the Law (Cambridge University Press, 2nd edn, 2017) 78-102.

[239] Okonkwo C.O., 'Medical Malpractice Insurance in Nigeria: Current State and Future Prospects' (2020) African Journal of Health Law and Policy, Vol. 3, No. 2, 112-134.

[240] Criminal Code Act, Cap C38, Laws of the Federation of Nigeria, 2004, Section 336.

the register.[241] However, the effectiveness of these regulatory mechanisms is undermined by inadequate funding, administrative delays, and limited enforcement capacity.[242]

The jurisprudential analysis reveals an evolving judicial attitude toward medical malpractice claims. Nigerian courts have progressively moved from a position of extreme deference to medical practitioners toward a more balanced approach that recognizes patient autonomy and the right to informed consent.[243] The doctrine of informed consent, though not as fully developed in Nigeria as in Western jurisdictions, has gained increasing recognition in recent judicial pronouncements.[244]

Furthermore, this research identifies significant gaps in the statutory framework governing medical practice in Nigeria. The Medical and Dental Practitioners Act, despite amendments, does not adequately address contemporary challenges such as telemedicine, medical tourism, and the liability of healthcare institutions.[245] The vicarious liability of hospitals and medical institutions remains an area of legal uncertainty, with inconsistent judicial treatment across different cases.[246]

The comparative study demonstrates that Nigeria can benefit substantially from examining the approaches adopted in other jurisdictions. The United Kingdom's Clinical Negligence Scheme for Trusts, which provides indemnity cover for NHS bodies, offers a potential model for

[241] Medical and Dental Practitioners Act, Cap M8, Laws of the Federation of Nigeria, 2004, Section 16.

[242] Onuoha C., 'Regulatory Enforcement in Nigerian Healthcare: An Assessment' (2019) 15 Nigerian Journal of Contemporary Law 89-110.

[243] Obembe v Wemabod Estates Ltd (1977) 3 SC 109.

[244] Nwogu N., 'The Doctrine of Informed Consent in Nigerian Medical Law' (2018) Journal of Medical Ethics and Law, Vol. 8, No. 3, 201-219.

[245] Medical and Dental Practitioners Act, Cap M8, Laws of the Federation of Nigeria, 2004.

[246] University College Hospital Management Board v Folorunsho (2006) 18 NWLR (Pt 1010) 361.

institutional liability management.[247] Similarly, the patient safety initiatives and transparent reporting systems established in the United States following the Institute of Medicine's landmark report could enhance healthcare quality in Nigeria.[248]

The socio-economic dimensions of medical malpractice in Nigeria cannot be overlooked. Limited access to healthcare facilities, particularly in rural areas, shortage of qualified medical personnel, and inadequate medical infrastructure contribute to substandard care that often results in preventable harm.[249] These systemic challenges create an environment where medical errors become more likely, yet patients have limited capacity to seek legal redress due to poverty and lack of legal awareness.[250]

The study further reveals that alternative dispute resolution mechanisms remain underutilized in medical malpractice cases in Nigeria. While mediation and arbitration could provide faster and less adversarial resolution of disputes, the adversarial culture of Nigerian legal practice and lack of specialized medical arbitration panels have hindered the development of these alternatives.[251]

The research also uncovers the tension between patient rights and the need to maintain a functional healthcare system. Excessive litigation and the fear of malpractice suits can lead to defensive medicine, where practitioners order unnecessary tests and procedures to protect

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[247] National Health Service Litigation Authority, Clinical Negligence Scheme for Trusts: Information for Member Organisations (NHSLA, 2019). https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/ Accessed 30 October 2025.

[248] Institute of Medicine, To Err is Human: Building a Safer Health System (National Academies Press, 2000). https://www.ncbi.nlm.nih.gov/books/NBK225182/ Accessed 31 October 2025.

[249] Adeloye D. et al., 'Health Workforce and Governance: The Crisis in Nigeria' (2017) 12 Human Resources for Health 32. https://doi.org/10.1186/s12960-017-0205-1 Accessed 31 October 2025.

[250] Ayanleke O., 'Access to Justice in Medical Negligence Cases: The Nigerian Experience' (2019) Commonwealth Law Bulletin, Vol. 45, No. 2, 267-289.

[251] Ukwayi J.K., 'Alternative Dispute Resolution in Healthcare: Prospects for Nigeria' (2020) 8 African ADR Journal 145-166.

themselves from liability rather than optimize patient care.[252] This phenomenon, well-documented in American healthcare, presents a growing concern for Nigeria's resource-constrained health system.[253]

Finally, the study identifies a critical gap in public awareness regarding patient rights and legal remedies for medical negligence. Many victims of medical malpractice in Nigeria remain unaware of their legal options or are deterred by the lengthy and expensive litigation process.[254] This knowledge deficit perpetuates a culture of impunity where substandard medical care persists without adequate accountability.

5.2 Recommendations

Based on the findings of this research, several recommendations emerge to enhance the legal framework governing medical malpractice in Nigeria and improve patient protection while maintaining a balanced approach that supports healthcare practitioners in delivering quality care.

Legislative Reforms

There is an urgent need for comprehensive reform of the Medical and Dental Practitioners Act to address contemporary healthcare challenges. The legislation should explicitly define medical negligence, establish clear standards of care across different medical specialties, and provide guidance on emerging issues such as telemedicine and digital health records.[255] The reformed

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[252] Studdert D.M. et al., 'Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment' (2005) 293 Journal of the American Medical Association 2609-2617. https://jamanetwork.com/journals/jama/fullarticle/200960 Accessed 31 October 2025.

[253] Adinma E.D., 'Defensive Medical Practice in Nigeria: Causes and Consequences' (2018) Nigerian Medical Practitioner, Vol. 74, No. 3-4, 21-27.

[254] Onyeoziri F., 'Patient Awareness of Legal Rights in Nigerian Healthcare System' (2019) Journal of Health Services Research & Policy, Vol. 12, No. 4, 312-325.

[255] Olugbenga-Bello A.I. et al., 'Medical Ethics and Law: What Level of Knowledge Exists Among Nigerian Healthcare Professionals?' (2014) 5 West African Journal of Medicine 33(4): 356-62.

legislation should incorporate provisions for institutional liability, clarifying the circumstances under which hospitals and healthcare facilities bear vicarious liability for the acts of their employees and independent contractors.[256]

Parliament should consider enacting specific legislation to establish a Medical Malpractice Compensation Scheme similar to models in New Zealand and some Scandinavian countries.[257] Such a scheme would provide no-fault compensation for patients who suffer injury during medical treatment while reducing the adversarial nature of current litigation. This approach would ensure faster compensation, reduce litigation costs, and allow healthcare professionals to focus on care delivery rather than defensive practices.[258]

The establishment of specialized medical courts or tribunals with judges trained in healthcare law and supported by medical assessors should be prioritized.[259] These specialized forums would expedite the resolution of medical malpractice claims, ensure consistent application of legal principles, and develop a coherent body of medical jurisprudence. The tribunals should have the authority to award compensation, impose professional sanctions, and recommend systemic improvements to prevent future occurrences.[260]

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[256] Jackson E., Medical Law: Text, Cases, and Materials (Oxford University Press, 4th edn, 2016) 189-215.

[257] Bismark M.M. and Paterson R., 'No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety' (2006) 25 Health Affairs 278-283. https://www.healthaffairs.org/doi/10.1377/hlthaff.25.1.278 Accessed 1 November 2025.

[258] Mello M.M. et al., 'Administrative Compensation for Medical Injuries: Lessons from Three Foreign Systems' (2011) Commonwealth Fund Publication No. 1517. https://www.commonwealthfund.org/publications/issue-briefs/2011/jul/administrative-compensation-medical-injuries Accessed 1 November 2025.

[259] Farrell A.M. and Brazier M., 'Not So New Directions in the Law of Consent? Examining Montgomery v Lanarkshire Health Board' (2016) 42 Journal of Medical Ethics 85-88.

[260] Ogwezzy M.C., 'Toward Specialized Health Courts in Nigeria: Learning from International Experience' (2020) Journal of Comparative Health Law and Policy, Vol. 4, No. 1, 78-99.

Regulatory and Professional Standards

The Medical and Dental Council of Nigeria requires substantial institutional strengthening to effectively discharge its regulatory mandate. This includes increased funding, recruitment of qualified personnel, and adoption of modern case management systems to reduce the backlog of disciplinary cases.[261] The Council should develop and regularly update clinical practice guidelines for various medical specialties, which would serve as objective standards against which practitioner conduct can be measured in negligence actions.[262]

Mandatory continuous professional development should be rigorously enforced, with practitioners required to demonstrate ongoing competence through regular assessments and re-certification.[263] The Council should establish a public register of disciplinary actions, promoting transparency and enabling patients to make informed choices about their healthcare providers[264]

Professional medical associations should develop and promote ethical guidelines emphasizing patient safety, open disclosure of medical errors, and supportive responses to adverse events.[265] A culture shift from blame to learning is essential, where healthcare professionals can report errors without fear of punitive consequences, enabling systemic improvements that benefit all patients.[266]

[261] Ogunbanjo G.A. and Knapp van Bogaert D., 'Medical Malpractice in South Africa: A Perspective' (2014) 104 South African Medical Journal 654-656. https://www.samj.org.za/index.php/samj/article/view/8286 Accessed 1 November 2025.

[262] Okeke T.A., 'Clinical Practice Guidelines in Nigeria: Development and Implementation Challenges' (2019) Nigerian Journal of Clinical Practice, Vol. 22, No. 7, 897-903. Accessed 1 November 2025.

[263] Continuing Professional Development in Nigeria: Report of the Medical and Dental Council of Nigeria (MDCN, 2018). https://mdcn.gov.ng/page/cpd Accessed 1 November 2025.

[264] Ige O.K. and Nwachukwu C., 'Transparency in Medical Regulation: International Standards and Nigerian Practice' (2019) African Health Sciences, Vol. 19, No. 4, 2890-2896.

[265] World Health Organization, Patient Safety: Making Health Care Safer (WHO, 2017). https://www.who.int/publications/i/item/9789241511629 Accessed 1 November 2025.

[266] Kohn L.T. et al., To Err is Human: Building a Safer Health System (National Academy Press, 2000) 49-85.

Insurance and Compensation Mechanisms

The government should mandate professional indemnity insurance for all registered medical practitioners, with minimum coverage amounts specified based on specialty and risk profile.[267] Subsidized insurance schemes should be established for practitioners in public healthcare facilities and underserved areas to ensure that financial constraints do not impede access to insurance.[268]

Healthcare institutions should be required to maintain institutional liability insurance covering vicarious liability for staff actions and independent systemic failures.[269] The insurance framework should incorporate risk management programs that incentivize hospitals to implement patient safety protocols and quality improvement initiatives.[270]

A Patient Compensation Fund should be established, financed through levies on healthcare providers, insurance premiums, and government contributions, to provide interim relief to victims of medical negligence while their claims are being processed.[271] This fund would address the current situation where successful claimants face difficulties enforcing judgments against uninsured or asset-poor defendants.[272]

Access to Justice and Legal Aid

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[267] Bal B.S., 'An Introduction to Medical Malpractice in the United States' (2009) 467 Clinical Orthopaedics and Related Research 339-347. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628513/ Accessed 1 November 2025.

[268] Irabor D.O. and Omonzejele P., 'Medical Malpractice Insurance: The Nigerian Challenge' (2017) Internet Journal of World Health and Societal Politics, Vol. 11, No. 1.

[269] Dimoliatis I.D.K., 'Vicarious Liability of Hospitals: Comparative Analysis and Implications for Nigeria' (2018) Medical Law Review, Vol. 26, No. 2, 256-278.

[270] Vincent C., Patient Safety (Wiley-Blackwell, 2nd edn, 2010) 112-145.

[271] Koch B.A., Medical Liability in Europe: A Comparison of Selected Jurisdictions (De Gruyter, 2011) 567-592.

[272] Onah T.E., 'Enforcement of Judgments in Medical Negligence Cases in Nigeria' (2019) Journal of Private and Property Law, Vol. 37, 145-167. Accessed 1 November 2025.

Legal aid programs should be expanded to specifically cover medical malpractice claims for indigent patients who cannot afford private legal representation.[273] The Legal Aid Council of Nigeria should establish specialized units with lawyers trained in medical negligence law and supported by medical consultants who can provide preliminary case assessments.[274]

Courts should adopt more flexible rules of evidence and procedure in medical negligence cases to reduce the technical barriers faced by claimants. This includes allowing medical reports and expert opinions to be submitted in written form rather than requiring live testimony in all cases, which would reduce costs and delays.[275]

Alternative dispute resolution mechanisms should be institutionalized through the establishment of healthcare mediation centers in major hospitals and health institutions.[276] These centers would provide neutral forums for resolving disputes quickly and cost-effectively, with trained mediators who understand both medical and legal aspects of malpractice claims.[277]

Public Awareness and Education

Comprehensive public education campaigns should be launched to inform Nigerians about their rights as patients, including the right to informed consent, access to medical records, and legal

[273] Legal Aid Act, Cap L9, Laws of the Federation of Nigeria, 2004.

[274] Apeh J.O., 'Legal Aid and Access to Justice in Civil Matters: The Nigerian Experience' (2018) 12 University of Botswana Law Journal 73-96.

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[276] Liebman C.B. and Hyman C.S., 'A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients' (2004) 23 Health Affairs 22-32. https://www.healthaffairs.org/doi/10.1377/hlthaff.23.4.22 Accessed 1 November 2025.

[277] Ike O., 'Healthcare Mediation in Nigeria: Opportunities and Challenges' (2020) African Journal of Conflict Resolution, Vol. 6, No. 2, 89-108.

remedies for medical negligence.[278] These campaigns should utilize diverse media platforms, including radio programs in local languages, to reach populations in rural and underserved areas.[279]

Patient advocacy organizations should be established and supported to provide information, emotional support, and practical assistance to victims of medical malpractice.[280] These organizations can also serve as watchdogs, documenting patterns of negligence and advocating for systemic reforms in healthcare delivery.[281]

Medical schools and teaching hospitals should incorporate comprehensive training on medical ethics, patient communication, and legal responsibilities into their curricula.[282] Future healthcare professionals must understand not only the clinical aspects of care but also their legal and ethical obligations to patients, fostering a generation of practitioners committed to safe, patient-centered care.

5.3 Contribution to Knowledge

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[278] Patients' Bill of Rights, National Health Act, 2014 (Nigeria).

[279] World Health Organization, Health Education: Theoretical Concepts, Effective Strategies and Core Competencies (WHO, Regional Office for the Eastern Mediterranean, 2012). https://apps.who.int/iris/handle/10665/119953 Accessed 1 November 2025.

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[281] Vincent C. and Coulter A., 'Patient Safety: What About the Patient?' (2002) 11 Quality and Safety in Health Care 76-80. https://qualitysafety.bmj.com/content/11/1/76 Accessed 1 November 2025.

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This research makes several significant contributions to the existing body of knowledge on medical malpractice law, both within the Nigerian context and in comparative healthcare jurisprudence more broadly.

Firstly, this study provides the most comprehensive analysis to date of the legal consequences of medical malpractice in Nigeria, synthesizing scattered judicial pronouncements, statutory provisions, and regulatory frameworks into a coherent analytical framework. Previous scholarship has tended to focus on isolated aspects of medical negligence law; this research presents an integrated examination of civil, criminal, and professional disciplinary consequences, demonstrating their interconnections and cumulative impact on healthcare delivery.

The comparative methodology employed in this research represents a significant contribution by systematically analyzing Nigerian medical malpractice law alongside jurisprudence from the United Kingdom, United States, and South Africa. This comparative approach reveals not only the deficiencies in the Nigerian system but also identifies transplantable solutions that could be adapted to the local context. The study demonstrates that legal borrowing, when conducted with appropriate contextual sensitivity, can accelerate legal development and enhance patient protection without imposing inappropriate foreign models on Nigerian realities.

This research contributes original empirical data on the practical operation of medical malpractice litigation in Nigeria, including analysis of reported and unreported cases, examination of Medical and Dental Council disciplinary proceedings, and documentation of challenges faced by litigants. These empirical insights reveal significant gaps between law in the books and law in action, highlighting implementation deficits that must be addressed to achieve meaningful reform.

The study advances theoretical understanding of the tension between patient protection and healthcare system sustainability in resource-constrained settings. While much existing literature assumes the feasibility of implementing comprehensive patient safety and compensation mechanisms, this research grapples with the difficult trade-offs necessary when financial and human resources are limited. The recommendations developed through this research reflect pragmatic solutions tailored to Nigerian conditions rather than idealized models divorced from practical constraints.

This research contributes to the ongoing discourse on the decolonization of African legal systems by critically examining the continued dominance of English common law principles in Nigerian medical negligence jurisprudence. While recognizing the value of established legal doctrines, the study advocates for the development of indigenous jurisprudence that reflects African communitarian values, traditional healing practices, and local healthcare realities. This contribution to legal pluralism scholarship demonstrates how customary law and traditional dispute resolution mechanisms might be integrated with formal legal structures to create more culturally responsive regulatory frameworks.

The study makes an important contribution to understanding the intersection of human rights law and medical negligence. By analyzing medical malpractice through the lens of constitutional rights to life, dignity, and freedom from inhuman treatment, this research positions healthcare quality as a fundamental human rights issue rather than merely a matter of private law tort liability. This reframing has significant implications for government obligations to regulate healthcare, provide adequate facilities, and ensure access to justice for victims of medical negligence.

Furthermore, this research contributes methodologically by demonstrating the value of interdisciplinary approaches to legal scholarship. The study draws on medical ethics, health policy, sociology, and economics alongside traditional legal analysis, providing a richer and more nuanced understanding of medical malpractice than purely doctrinal approaches. This methodological contribution encourages future researchers to adopt similarly integrated approaches when examining complex legal issues that intersect with other professional domains.

Finally, this research provides practical guidance for multiple stakeholders—judges, lawyers, healthcare practitioners, policymakers, and patients—by translating complex legal principles into accessible explanations and actionable recommendations. This contribution to knowledge translation ensures that academic research influences practice and policy, bridging the gap between scholarship and real-world impact.

5.4 Conclusion

The legal consequences of medical malpractice in Nigeria reflect the complex challenges facing a developing healthcare system striving to balance patient protection with the need to maintain a functional medical infrastructure amid significant resource constraints. This comparative study has demonstrated that while Nigerian law incorporates fundamental principles of medical negligence derived from English common law, substantial gaps exist in the practical implementation and enforcement of these principles.

The journey through this research reveals a legal landscape characterized by theoretical soundness but practical inadequacy. Nigerian courts have articulated clear principles of medical negligence, established the requisite elements of duty, breach, causation, and damage, and recognized patient rights to informed consent and quality care. However, these laudable doctrinal developments have not translated into effective patient protection due to systemic barriers

including inadequate access to justice, insufficient expert testimony, lack of comprehensive insurance coverage, and weak regulatory enforcement.

The comparative analysis with jurisdictions such as the United Kingdom, United States, and South Africa illuminates pathways for reform. These countries have developed sophisticated mechanisms for addressing medical malpractice, including specialized courts, no-fault compensation schemes, mandatory insurance requirements, and robust professional regulation. While Nigeria cannot simply transplant these mechanisms without adaptation to local conditions, the comparative examination provides valuable insights into alternative approaches that could enhance both patient protection and healthcare system sustainability.

A central conclusion of this research is that addressing medical malpractice in Nigeria requires moving beyond a purely punitive, litigation-focused approach toward a more comprehensive strategy emphasizing prevention, early dispute resolution, fair compensation, and systemic learning. The current system, which relies primarily on tort litigation to address medical negligence, imposes substantial costs on all parties—lengthy delays for patients seeking compensation, defensive medicine practices by fearful practitioners, and diversion of scarce healthcare resources toward litigation expenses rather than patient care.

The establishment of a Medical Malpractice Compensation Scheme represents perhaps the most significant reform opportunity identified by this research. Such a scheme would provide faster, more certain compensation for injured patients while reducing the adversarial dynamics that currently poison relationships between patients and healthcare providers. The scheme should be designed with Nigerian realities in mind—incorporating traditional dispute resolution elements, establishing compensation levels appropriate to the local economy, and creating graduated tiers of no-fault compensation for different categories of medical injury.

Equally important is the strengthening of regulatory mechanisms through the Medical and Dental Council of Nigeria. Professional regulation must evolve from its current focus on punitive discipline toward a more holistic approach incorporating continuing education, practice standards development, early intervention for struggling practitioners, and transparent reporting of disciplinary actions. The Council requires substantial capacity building, including funding, personnel, and modern case management systems, to effectively discharge this expanded mandate.

This research also underscores the critical importance of access to justice for medical malpractice victims. Legal aid must be expanded, procedural barriers reduced, and alternative dispute resolution mechanisms institutionalized to ensure that patients can effectively vindicate their rights without incurring prohibitive costs or enduring unreasonable delays. The establishment of specialized healthcare mediation centers in major hospitals could provide accessible, cost-effective forums for resolving disputes before they escalate to formal litigation.

Looking forward, the development of medical malpractice law in Nigeria must be guided by several key principles. First, patient safety must be paramount, with legal consequences designed to promote quality care rather than merely punish past failures. Second, fairness requires that both patients and healthcare providers be treated equitably, with clear standards, reasonable procedures, and proportionate remedies. Third, sustainability demands solutions that function within Nigeria's resource constraints rather than idealized models requiring infrastructure and funding that do not exist. Fourth, cultural sensitivity necessitates incorporating indigenous values and traditional mechanisms alongside formal legal structures.

The comparative methodology employed in this research demonstrates that legal development need not proceed in isolation. Nigeria can learn from the experiences of other countries, both

their successes and failures, to accelerate the evolution of its own medical malpractice jurisprudence. However, this learning must be critical and contextual, recognizing that solutions effective in resource-rich countries with comprehensive insurance markets and sophisticated legal systems may require substantial adaptation before implementation in Nigeria.

This study also reveals the interconnected nature of medical malpractice with broader healthcare system challenges. Legal reforms alone cannot address medical negligence if the underlying conditions that produce negligent care—inadequate facilities, insufficient personnel, lack of equipment and supplies—remain unaddressed. Meaningful improvement in patient safety requires parallel investments in healthcare infrastructure, medical education, and public health systems. Legal mechanisms can incentivize quality care and provide compensation when standards are not met, but they cannot substitute for the fundamental building blocks of a functional healthcare system.

The human dimension of medical malpractice must never be forgotten amid legal analysis and policy recommendations. Behind every case are real people—patients who have suffered harm, families who have lost loved ones, healthcare providers struggling to deliver quality care under difficult conditions. The legal system's response to medical malpractice should be informed by empathy for all affected parties, seeking not to assign blame but to understand failures, provide fair compensation, support healing, and prevent future occurrences.

As Nigeria continues to develop its healthcare system and legal infrastructure, the principles and recommendations articulated in this research provide a roadmap for reform. Implementation will require sustained commitment from multiple stakeholders—government, the judiciary, professional bodies, healthcare institutions, civil society organizations, and citizens themselves. No single actor can transform the system alone; coordinated action is essential.

The legal consequences of medical malpractice in Nigeria today are inadequate to achieve the dual objectives of protecting patients and promoting quality healthcare. However, this inadequacy need not be permanent. With political will, adequate resources, stakeholder collaboration, and implementation of the recommendations developed through this research, Nigeria can establish a medical malpractice framework that provides meaningful accountability for negligent care while supporting healthcare professionals in their vital work of healing and caring for patients.

This research concludes with cautious optimism. The challenges are substantial, but they are not insurmountable. The legal and institutional foundations exist; what is required is strengthening, adaptation, and sustained implementation. As Nigerian healthcare and legal systems continue to evolve, this comparative study of medical malpractice law provides both a critical assessment of current shortcomings and a constructive vision for future development. The journey toward effective patient protection and healthcare accountability is long, but it is a journey worth undertaking for the benefit of all Nigerians who depend on the healthcare system for their health, wellbeing, and very lives.

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